

# **SURINAME: HIV/TB Sustainability Action Plan**

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**Final Report**

**Pharos Global Health Advisors  
for the Global Fund**



## **Authors and Acknowledgements**

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## 2 Acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Anti Retroviral Treatment
ARV	Anti Retro Virals
AZP	Academisch Ziekenhuis Paramaribo (Academic Hospital Paramaribo)
BGVS	Bedrijf Geneesmiddelen Voorziening Suriname
BOG	Bureau Openbare Gezondheidszorg (Bureau of Public Health)
CARPHA	Caribbean Public Health Agency
C-CCM	Caretaker Country Coordinating Mechanism
CL	Central Laboratory
COVID-19	Corona Virus Disease 2017
CSO	Civil Society Organization
DOT	Directly Observed Treatment
DR	Drug-resistant
GDP	Gross Domestic Product
GFATM	Global Fund to fight against AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HR-desk	Human Rights desk
IADB	Inter-American Development Bank
IC	Investment Case
IR	Investment Report
KP	Key Population
M&E	Monitoring and Evaluation
MDR	Multidrug-resistant
MM	Medical Mission
MoF	Ministry of Finance
MoH	Ministry of Health
MSM	Men who have Sex with Men
MSAH	Ministry of Social Affairs and Housing
NGO	Non-Governmental Organization
NAP	National AIDS Program
NCD	Non-Communicable Diseases
NSP	National Strategic Plan
NTP	National Tuberculosis Program
PAHO	Pan American Health Organization
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
P&SCM	Procurement & Supply Chain Management
RGD	Regionale Gezondheidsdienst (Regional Health Services)
RIVM	Rijkinstituut voor Volksgezondheid en Milieu (National Institute for Public Health and the Environment)
RR	Rifampicin Resistant
SF	Strategic Fund
SC	Social Contracting

SOP	Standard Operating Procedure
S&T	Sustainability & Transition
SS	Sustainability Strategies
SW	Sex Worker
SZF	StaatsZiekenFonds(State Health Insurance Foundation)
TA	Technical Assistance
TB	Tuberculosis
TLD	Tenofovir Lamuvidine Dolutegravir
TOR	Terms of Reference
TRA	Transition Readiness assessment
TWP	Transition Work Plan
WHO	World Health Organization

# 1 Executive Summary

## 1.1 Objective and scope of work: Sustainable transition away from donor funding

- The 2016 Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF) policy states that all upper-middle-income countries regardless of disease burden, and all lower-middle-income countries with low/moderate disease burden should prepare early and systematically for the phase-out of GF support.
- To ensure that the gains achieved with GF support are preserved and progress is sustained following donor exit, the GF recommends that countries develop sustainability strategies to define a clear work plan with concrete actions to enable effective domestic take-up of GF-financed activities and strengthen key areas of the national response for the three diseases.
- Suriname has made progress in the past few years to prepare for transition. The Global Fund commissioned a *Transition Readiness Assessment (TRA)* to the international consultancy firm ICF in 2016. The document review and stakeholder consultations resulted in the beginning of 2018 in and an initial draft of a TRA and a *Transition Work Plan (TWP)*. In addition, a draft '*Sustainability Plan for the Suriname national response for HIV, TB and Malaria*' was developed with support from USAID and Health Finance and Governance (Abt Associates). Stakeholders' consultation and feedback were ongoing when the process halted in the same year.
- Some of the recommendation from this previous work were incorporated into the HIV and TB response and financed through the current grant (with implementation period 2019-2021). Nevertheless, as transition nears it becomes crucial to narrow down the priority actions to better target the efforts for a successful transition.
- As part of the next steps in the transition process, the GF commissioned Pharos Global Health Advisors to produce, based on previous work and on stakeholder consultations, a strong country-owned sustainability strategy for Suriname for the period 2021-24, that highlights the priority actions to expand, strengthen, and sustain national HIV and TB responses, and lay the groundwork for a smooth transition from GF assistance.
- This ***Sustainability Action Plan*** is the result of several months of work, which included document reviews and extensive stakeholder consultations. The Sustainability Action Plan identifies the main risks to a sustainable transition and develops 4 strategies with associated actions to address these risks. It should serve as input to help Suriname prepare the next funding request to the Global Fund.

## 1.2 Partnership between Suriname and The Global Fund

- Since 2004, the Global Fund to Fight AIDS, Tuberculosis, and Malaria has granted more than US\$17 million to support HIV, TB and malaria in Suriname.
- The malaria allocation for 2020-2022 is US\$3.2M, an almost 50% increase from the previous funding cycle to support Suriname's goal of eliminating the disease.
- The current grant of US\$1.8 million ends in December 2021. This grant included the last transition funding for TB, as well as resources for HIV prevention programs for key population groups with high burden of disease, care and treatment services, and efforts to strengthen the monitoring & evaluation of disease evolution and disease response.

- **The HIV grant for the allocation period 2020-22, which will be implemented between 2022-2024 is US\$2.3M, a significant increase from the previous funding cycle to incentive Suriname to make investments to reach the HIV 90-90-90 targets.**

### 1.3 Progress and Challenges

- Suriname has made important progress in the fight against the three diseases:
  - Suriname has been **recognized as a leader in innovation and malaria control and the country is close to elimination**, with zero recorded deaths since 2014.
  - Suriname has also **progressed significantly towards Tuberculosis (TB) elimination**. TB screening in 2013 was four times the level reached in 2010, 75% of all TB cases were successfully treated in 2015, and as of 2019 98.6% of TB patients know their HIV status.
  - **Progress has also been made towards reaching the 90-90-90 HIV targets**. Currently 83% of those diagnosed are on antiretroviral (ART) treatment (second 90 of the cascade) up from 80% in 2016 and 65% in 2013. Of those on treatment 90% have been virally suppressed (third 90 of the cascade), up from 77% in 2016 and 68% in 2013.
  - Suriname has made important progress towards a sustainable transition including the absorption of budget lines previously financed by donors, with specific lines for HIV and TB drugs and commodities, and improvements in reaching Key Populations with the support of Civil Society Organizations(CSO).
- However, some challenges remain which prevented Suriname from achieving its initial goal of reaching the 90-90-90 global targets by 2020:
  - There are an estimated **5,800 persons living with HIV in Suriname, with an HIV prevalence among adults aged 15–49 of 1.4%, well above the Latin-American and the Caribbean average of 0.44%**. Key Populations are disproportionately affected, including men who have sex with men (16.6% for 2018), and sex workers (10.8% for 2018).
  - **Only 59.4% of those estimated to be living with HIV know their status** (first 90 of the cascade), which translates into only 44% of all Persons Living with HIV (PLHIV) achieving viral suppression.
  - Around **a third of persons are diagnosed at a late stage** in the disease.
  - In 2019 there was a **sudden increase in HIV prevalence among TB patients** with more than 25% of TB patients being HIV positive, which coincided with reduced funding from the GF.

### 1.4 Sustainability and Transition Risks and Key Recommendations

- Reaching the 90-90-90 targets and progressing towards 95-95-95 goals will require stepping-up the response both in terms of resources and programmatic actions. Although the country is well positioned to assume these challenges there are several risks that need to be addressed.
- **Risk 1: The largest risk for a sustainable transition is the lack of a continuous and secure flow of funds for HIV.** Suriname was coming out of a steep economic recession which resulted in increased fiscal deficit and high debt, as well as external imbalances that limited the availability of foreign currency needed to import HIV commodities. The Covid-19 pandemic has halted the nascent economic recovery. Additionally, donor funding is dwindling. PEPFAR

is no longer financing activities in Suriname, and the country is transitioning away from Global Fund financing.

- **Recommendation 1: Develop a clear explicit funding strategy that identifies the sources to fund an increase of at least US\$1.4 million by 2024.** Based on the Investment Case Study this is the minimum amount needed in order to reach the 90-90-90 targets by 2024. Developing the funding strategy can be achieved through national stakeholder engagement with the support of a technical assistance project which should:
  - Identify and quantify the potential resources from the private sector that could be channeled to HIV actions, aided by a mapping of private sector philanthropies and social responsibility efforts, and a joint work with business and mining industry leaders.
  - Identify and exploit synergies with investments from other international donors. For example, countries with strong HIV/TB programs were able to leverage testing and tracing teams, outreach programs and laboratory capacity to better counter the Covid-19 epidemic. There is a strong argument for using resources from grant for disaster resilience to invest in these areas of the HIV response. The HIV response can benefit too from grants strengthening service provision for chronic conditions. There are important synergies with the current IDB loan, which should be explicitly incorporated in the financing strategy.
  - Identify, quantify and secure potential sources from other international donors. The Dutch government in particular is the fourth largest funder of HIV programs geared towards key populations, and 10% of all funding for KP comes from private philanthropies. Once the technical assistance has identified these donors, the Ministry of Health (MoH) should make a formal request to the Ministry of Finance to support grant seeking.
  - Identify and act to materialize potential savings from pooled procurement as well as from savings identified through previous studies, including the study of the efficiency of peer navigators and buddies (included in current grant).
  - Using the results from technical assistance project included in previous grant decide which services related to HIV, TB and malaria can be targeted for cost recovery, identify potential sources of income through this route, and refine and implement the plan to materialize these sources of income.
  - Identify the convenience of financing HIV commodities and treatment through health insurance, which would allow for additional income, through future premium increases, and reduce the volatility and uncertainty of public fund disbursements.
- **Risk 2:** Suriname has witness **recurring stock-outs which pose a threat to adequate treatment and discourages the uptake of testing**, as people anticipate treatment will not be available. Prevention efforts are also hampered by condom and test stock-outs. Although the stock-outs have been more severe as a result of the current economic and public health crisis, the stakeholder consultations evidenced that structural factors and inefficiencies in the procurement and supply chain management play an important role. Important advances have been made in forecasting commodity needs, but other areas of the supply chain need attention, including securing the funds for purchasing and timely disbursement of funds -which has played an important role in stock-outs-, advancing pooled procurement strategies to access better prices, and more efficient distribution of commodities.
- **Recommendation 2:** To address this issue the country would benefit from a **technical assistance to identify bottlenecks and inefficiencies in procurement and supply chain management, as well as devising a mechanism to secure the timely disbursement of funds**. In particular:

- Currently PAHO and UN are providing technical assistance in supply chain management and will continue to do so in the coming months. The work should explicitly identify bottlenecks in supply chain management and disbursement of funds, and recommend the optimal institutional arrangement for an efficient procurement and supply of commodities. Standard operating procedures should be formalized, making sure personnel are trained in any new procedure. A monitoring and evaluation systems should be implemented to understand the effectiveness of the measures deployed and make the necessary adjustments.
  - There is an urgent need to devise a mechanism to secure funding for ARV's (whether through health insurance or by direct government funding), as well as to secure the timely disbursement of funds. One such mechanism could be the establishment of an emergency fund to draw from when the timing of disbursements poses an imminent risk of stock-outs. The fund would be replenished once the funds are disbursed. Alternatively, a special funded account administered by MoH or BGVS can established by law, so that MoH does not have to request the funds for each procurement cycle.
- **Risk 3: Civil Society Organizations (CSO) are heavily funded by donors and provide an important share of services to KP and other PLHIV.** Withdrawal of donor funding has already resulted in gains lost. For example, MoH data shows a decrease of 50% in KP outreach outcomes in 2019 compared to 2018, which coincided with the halting of the LINKAGES project financed by PEPFAR. After a steady decrease since 2014 TB also saw an increase in the number of patients in 2017-2018, which coincided with the reduction of funding from GF.
- **Recommendation 3: Rolling out social contracting and launching a pilot is a priority for a sustainable transition that maintains the gains achieved in reaching KPs.** Suriname has made important progress towards social contracting, and there is a clear roadmap. However, roll-out of SC has halted. The GF grant for the period ending in 2021 did not include activities to roll-out SC. The next grant should give priority to rolling out SC and implementing the first pilot, with Suriname co-financing the initial stages, through the co-financing requirements and the GF grant financing the first pilot and CSO's trainings. This will require:
- Setting a new timeline for deploying the Social Contracting Roadmap.
  - Agreeing on a package of services -including psychosocial support, finalizing the costing and approving the budget for the first pilot.
  - By means of a technical assistance project, develop jointly with Suriname's CSO a new funding strategy and provide training for public contracting, grant finding and provision and marketing of services to the private sector.
  - Train CSO to engage in strategic discussion and decision making, including a first hands on training to participate in the regulation of social contracting.
  - Developing the needed regulation and procedures.
  - Launching the Social Contracting pilot
- **Risk 4: Stigma and discrimination are still important drivers of low testing uptake** and are a hurdle to finding the 3,4000 PLHIV without a diagnostic. Stigma and discrimination toward key and affected populations is widespread, existing within the general population and the health system. It is not only a result of ingrained cultural beliefs, but also of lack of knowledge and information regarding treatment, prevention and modes of transmission. Additionally, stigma and discrimination results in violation of human rights of KP.

- **Recommendation 4: Address barriers to finding the 3,400 PLHIV that are still undiagnosed, by:**
  - Developing a health literacy and communication campaign, based on best practices and evidence, as well as the results from previous studies on barriers to access. The campaign should become a routine part of the HIV response, rather than a one-time event.
  - Establishing a system of redress of violation to Human Rights for KP.
  - Rolling-out self-test, as self-testing has proven to be a successful strategy to increase testing uptake by providing a safe and confidential alternative to provider testing.
  
- **In addition** to the four strategies recommended in this document, **it is important to strengthen the institutional capacity of the HIV program** to enable the successful implementation of these strategies and other actions in the HIV response. This has been addressed in the National Strategic Plan for HIV for the coming period, so it is not covered in this report.
  
- Increasing the investments and programmatic response **can avert 1,396 death and 1,850 new infections**. This will not only result in better health status and quality of life for many, but will translate in lower health service and health insurance costs for the government, less social assistance requirements, and will prevent loss of productivity due to ill health and death of those affected by HIV.

## 2 Introduction

### 2.1 The challenge of HIV and TB Sustainability and Transition. Context and Issues

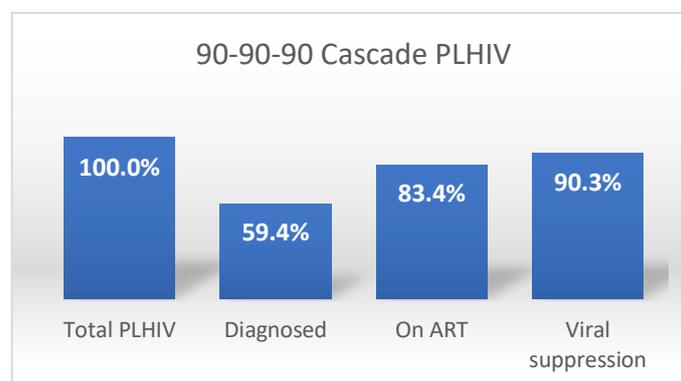
#### 2.1.1 Sustainability challenges in Suriname

The 2016 Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF) policy states that all upper-middle-income countries regardless of disease burden, and all lower-middle-income countries with low/moderate disease burden should prepare early and systematically for the phase-out of GF support, especially countries whose per capita incomes continue to grow and whose HIV/TB/malaria disease burden is declining. As part of this process, the GF recommends that countries develop sustainability strategies (SS) and use these to define a clear work plan with concrete actions to enable effective domestic take-up of GF-financed activities and strengthen key areas of the national response for the three diseases. This process is vital to ensure that the gains achieved with GF support are preserved and sustained, and that countries maintain and improve the effectiveness, and efficiency of their national disease control programs following donor exit.

Suriname's National AIDS Program's (NAP) efforts to progress toward reducing the transmission of HIV have been relatively successful as with the introduction of 'Test and Treat'. An increasing number of diagnosed People Living with HIV (PLHIV) (2019) are on treatment (83.4%) and achieving an undetectable viral load (90.3%). Still, Suriname has yet to improve its testing strategies, as only 59.4% of those estimated to be living with HIV know their status, which translates into only 44% of PLHIV achieving viral suppression. This means that Suriname will not achieve its goal of reaching the 90-90-90 targets by 2020.

Additionally, prevalence among certain groups is high, with 16.6% of men who have sex with men and 10% of male sex workers and Transgender sex workers being HIV positive<sup>1</sup>. Although new outreach and other prevention strategies targeted to key populations have been implemented since 2016, they are mainly executed by CSOs, which are heavily reliant on donor funding. Moreover, after the halting of the LINKAGES project, the number of MSM reached has halved.

Figure 1: HIV cascade Suriname 2019



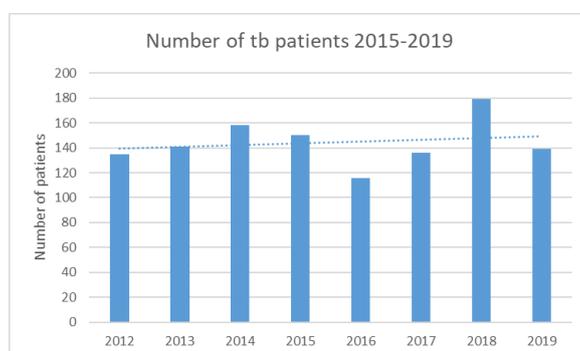
Source: MOH, Suriname Draft Epi Profile 2014-2019

<sup>1</sup> <https://kpatlas.unaids.org/dashboard>. Retrieved Oct 31<sup>st</sup>, 2020.

Suriname has also progressed significantly towards Tuberculosis (TB) elimination. TB screening in 2013 was four times the level reached in 2010, 75% of all TB cases were successfully treated in 2015, and as of 2019 98.6% of TB patients know their HIV status. Similarly, in the period 2012-2017 25.2% of the tuberculosis patients had an HIV co-infection, in 2018 this was 16.7% (1 in 6)<sup>2</sup>. In 2019 this percentage increased to 27.0% (1 in 4)<sup>3</sup>

Despite these significant gains, the number of TB patients is increasing. In 2018 one hundred and seventy-nine patients were diagnosed, which was the highest number since 2010 and second highest this century. The notification rate in 2019 was 23.9 per 100,000 inhabitants, with the highest incidence reported among the age group 55 years and older. Although the HIV prevalence among TB patients was declining, in 2019 it shows a sudden increase again with more than a quart of TB patients being HIV positive. Isoniazid Preventive Therapy (IPT) is not routinely given to HIV patients.<sup>4</sup> This increase coincides with the reduction of donor funding for TB in the country.

Figure 2: Notification 2015-2019



Source: MOH, Suriname Surveillance tuberculose 2019

The support from national health and non-health stakeholders and development partners has been crucial for these gains. Nevertheless, coordination and communication can be strengthened and, insufficient human capacity and funding, as well as stigma and discrimination, continue to be inhibiting factors towards achieving better results.<sup>5</sup>

The current economic crisis and the COVID-19 pandemic, which required re-direction of funds, are posing great challenges for maintaining the level of HIV response that has been achieved. Moreover, domestic funding is needed for adequate attention to prevention activities towards youth and the general population, to assume the financial responsibility for the work done by CSOs and to address stigma and discrimination in order to increase the number of PLHIV who know their status (first 90).

### 2.1.2 Previous work on sustainability and transition

In the past several years, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF) has conducted sustainability/transition preparedness analyses and planning exercises in many countries, in an effort to support upper-middle-income and all lower-middle-income countries to timely prepare for the phase-out of GF support.

<sup>2</sup> Ministry of Health. (2019). Surveillance van tuberculose in Suriname, 2012-2018. Paramaribo: Suriname Government.

<sup>3</sup> Ministry of Health. (2020). Surveillance van tuberculose in Suriname, Paramaribo: Suriname Government

<sup>4</sup> Ministry of Health. (2020). Draft Suriname HIV Epidemiological Profile, 2014 – 2019. Paramaribo: Suriname Government.

<sup>5</sup> Ministry of Health. (2020). Final Draft Evaluation and Situation and Response Analysis of the HIV NSP 2014-2020. Paramaribo: Suriname Government. Stakeholders interviews for the Sustainability Action Plan

As part of this process, the GF recommends that countries develop Sustainability Action Plans to plan concrete actions that enable effective domestic take-up of GF-financed activities and strengthen key areas of the national response for the three diseases. This process is vital to ensure that the gains achieved with GF support are preserved and sustained over time, and that countries maintain and further enhance the quality, effectiveness, and efficiency of their national disease control programs.

To support Suriname, the Global Fund commissioned the international consultancy firm ICF in 2016 to start the planning process of transitioning funding. The document review and stakeholder consultations resulted in the beginning of 2018 in a Transition Readiness Assessment (TRA) and an initial draft of a Transition Work Plan (TWP), translated from the identified risks and opportunities. A 'Sustainability Task Force' (STF), chaired by the Director of Health of that period, was established to ensure multi-sectoral input into the planning process as well as oversight of the process. Nevertheless, this STF was not active in the past few years. In addition, a draft 'Sustainability Plan for the Suriname national response for HIV, TB and Malaria' was developed with support from USAID and Health Finance and Governance (Abt Associates, Bethesda Maryland). Stakeholders' consultation and feedback were ongoing when the process halted in the same year.

### 2.1.3 Progress in implementing earlier recommendations

Suriname has made progress in the past few years to prepare for transition, including a UNICEF-sponsored CSO mapping exercise, the development of a social contracting roadmap and implementation plan supported by HP+, and the initial costing of prevention and promotion packages for social contracting. The country has also increased HIV/TB budget with specific lines for HIV/TB drugs and commodities and has absorbed part of the human resources previously financed with GF grants, particularly in the TB program. The Ministry of Health pays all salaries of the NAP staff.

The 2019 closure of USAID's LINKAGES project, which supported government- and CSO-delivered HIV services for KPs, has added pressure on the Ministry of Health to accelerate the establishment of a social contracting mechanism.

## 2.2 Objectives of the Sustainability Action Plan

Suriname remains eligible for HIV and TB funding from the Global Fund (GF), but as an upper-middle-income country it should prepare for the phase-out of GF support<sup>6</sup>. The country has been moving towards a sustainable transition strategy. In 2017, with support from ICF, Suriname conducted a Transition Readiness Assessment.<sup>7</sup> The assessment translated into the Transition Work Plan, a detailed set of objectives, strategies and activities that would need to be implemented to prepare for the transition. The country has been implementing some of these activities, part of which have been financed with the current GF grant ending in December 2021.

As part of the next steps in the transition process, the GF commissioned Pharos Global Health Advisors to produce a strong country-owned National Sustainability Strategy (SS) for Suriname for the period 2021-25, that highlights the priority actions to expand, strengthen, and sustain national HIV and TB responses, and lay the groundwork for a smooth transition from GF assistance. This SS will

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<sup>6</sup> For the 2020-2022 allocation period the country did not receive a TB grant but rather is implementing transition funding for TB through the joint HIV/TB grant. This merging of the grants has increased collaboration between the TB and HIV programs.

<sup>7</sup> ICF, *Suriname Transition Readiness Assessment. Final Report* (February 12 2017).

build upon the sustainability & transition analyses performed during 2017/2018, identifying a reduced set priority actions that still need to be undertaken, as well as other actions not identified previously, which are important to sustain Global Fund investments in Suriname and strengthen the national HIV and TB responses. The SS can serve as input to inform the next funding request.

### 2.3 Methods and Process

The work was structured around four phases: An initial phase to understand the progress of actions recommended in the TWP and to identify priorities for action through stakeholder consultations and document reviews; a second stage of workshops with key stakeholders to validate the priorities identified in the first stage; a third stage to advocate for the adoption of the sustainability action plan (SAP); and a final stage to identify three critical activities in which assistance is required for the preparation of Terms of Reference for their implementation.

**Initial stage.** After an introductory letter from the Global Fund to the Ministry of Health (MoH), early dialogue began with the Caretaker Country Coordination Mechanism (C-CCM) and with the MoH appointed points of contact, Monique Houtin (MoH focal point for HIV) and Eric Commiesie (HIV/TB GF grant coordinator). The points of contact provided valuable support in liaising with the MoH and key stakeholders.

In a parallel a review of secondary literature was performed to identify emerging recommendations from previous studies; the degree of evolution and implementation of the recommendations from TWP and other studies; the emerging effects of COVID-19, and involvement of other donors in the region.

Pharos worked closely with the C-CCM chair and vice-chair and the point of contacts to understand the stage of adoption and implementation of the recommended activities, and a list of priorities that were still pending was identified<sup>8</sup>. This list was the starting point for the stakeholder consultation.

Individual and group semi-structured virtual interviews were carried out with key stakeholders, including MoH and Ministry of Finance (MoF) officials, laboratories, providers, other international and multilateral organizations working in the region, and CSOs, among others. The interviews started with a presentation by Pharos of the risks and recommendation identified in the TWP. After the presentation a set of open-ended questions were formulated aiming to: i) further understand which recommendations mentioned in the TRA and/or included in the Transition Work Plan have been implemented, which ones have not and for what reasons; ii) investigate the existence of new risks to the sustainability of responses to HIV and TB that have not been captured in previous studies; and iii) capture individual prioritization of risks and recommendations. At the end of the discussion, interviewees were asked to select the three most important recommendations to guarantee sustainability of the HIV response.

Additionally, Pharos met with the team of consultants developing the National Strategic Plan for HIV (NSP) 2020-2024. The purpose of the meeting was to identify shared objectives and possible synergies, and align the work so that recommendations included in the Sustainability Action Plan can be incorporated in the NSP. A member of the NSP team was invited to sit in Pharos' interviews with

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<sup>8</sup> Additionally, a detailed review of the TWP matrix was carried out by Pharos consultants and compared to the recommendations in the Sustainability Action Plan developed by the MoH with support from PEPFAR in order to identify shared priorities.

stakeholders, and a Pharos team member was invited to sit in the stakeholder consultations of the NSP. (Annex 1 lists stakeholders interviewed and NSP meeting in which Pharos participated).

During this stage Pharos has been working with the points of contact to integrate a Sustainability and Transition Steering Committee which would aid in the monitoring and follow-up of the recommendations (Annex 1 lists the proposed members of the steering committee).

**Elaboration phase:** In coordination with the points of contact appointed by the MoH, GF and the C-CCM, Pharos organized a workshop via videoconferences with a representative group of stakeholders to validate the priority actions previously identified through the interviews and document reviews. This workshop had representation from the government, civil society, donors, and other institutions from the health sector. The risk matrix and prioritized recommendations agreed upon in this workshop are the central part of the Sustainability Action Plan.

**Approval phase:** The Pharos team will work hand in hand with the C-CCM, national actors and the FM to advocate for the adoption of the Sustainability Action Plan by the Suriname Ministry of Health. Based on the Sustainability Action Plan, Pharos prepared a policy brief and PowerPoint presentation of prioritized risks and recommendations, to present it to the Ministry of Health and Finance officials.

**ToRs preparation phase:** Pharos and the national actors selected three critical activities for which assistance is required for the preparation of Terms of Reference (TORs). These activities are: 1) Development of a funding strategy to identify the sources of finance to close the resource gap, that is needed to reach the 90-90-90 targets, and continue to move towards 95-95-95; 2) Development of a funding strategy for CSO's, including a portfolio of services and training for seeking and applying for grants application; and 3) The development a health literacy and communication campaign geared towards the general population, using evidence based best practices, 4) Alternative mechanisms to prevent liquidity constraint and disbursement delays from causing HIV commodities stock-outs

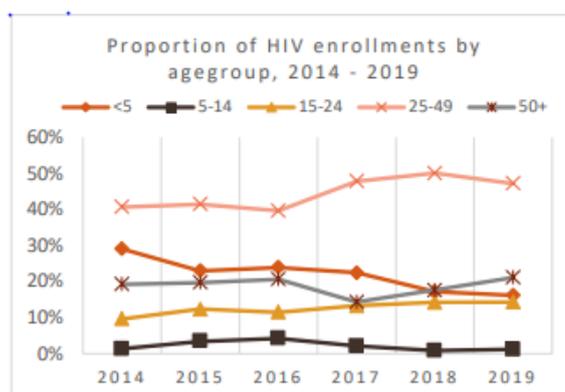
## 3 Background

### 3.1 Epidemiological and Programmatic Background

#### 3.1.1 Epidemiological Background

According to 2019 UNAIDS estimates in Suriname's generalized epidemic 5800 (4600-6900) people were living with HIV (PLHIV), of whom 3100 are estimated to be males and 2500 females 15-49 years old. Data from the Ministry of Health show that of the enrolled HIV cases in 2019 forty-seven percent was in the age group 25-49 years and 21% was 50 years of age or older. Approximately 15% of the newly enrolled HIV cases were among youngsters aged 15-24 years.

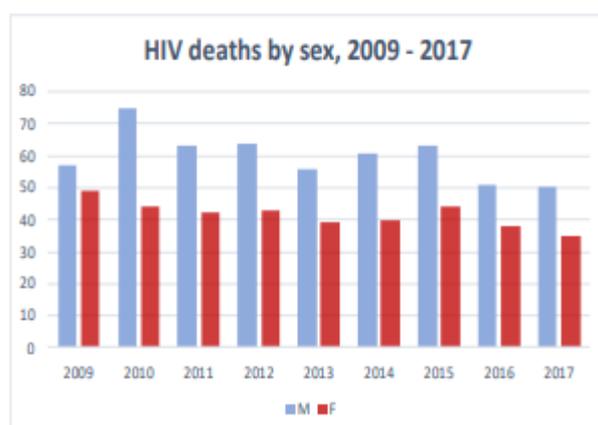
Figure 3: HIV enrollment by age groups



Source: MOH, Suriname Draft NSP 2021-2027

The number of deaths due to HIV gradually declined from more than 100 in 2009 to 85 persons in total in 2017. The mortality rate went from 20.3 in 2009 to 14.9 per 100,000 in 2017 (a decrease of 26% in less than 10 years).

Figure 4: HIV deaths by sex



Source: MOH, Suriname Draft NSP 2021-2027

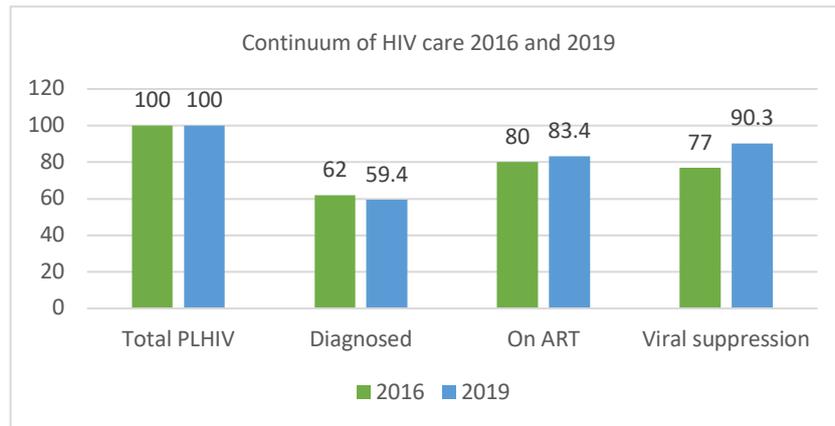
The prevalence among adults 15-49 years in the general population is 1.4 % but HIV prevalence among key populations is significantly higher and in particular among SW (10.8% for 2018) and MSM (16.6% for 2018)<sup>9</sup>. Sex workers (SW) accounted for an increased prevalence of 10 % compared with 5.86% in the IBBSS of 2012. The higher prevalence seems to be primarily due to an increased HIV prevalence among male SW and trans SW as the prevalence among FSW is only 1%<sup>10</sup>.

Of all PLHIV, only 59.4% know their HIV status, which represents a minimal increase compared to 2013 (58.2%). Among women 75% know their HIV status compared to only 50% of men. According to UNAIDS KP atlas, 97% of MSM LHIV know their status. Both the treatment coverage and the viral suppression among those on treatment did improve, particularly in 2018. From the estimated 5800 PLHIV in Suriname in 2019, while only 50% were receiving treatment, 83.4% of those diagnosed were linked to treatment, and from those linked to treatment 90.3% achieved viral suppression.

<sup>9</sup> UNAIDS. Key Population Atlas. <https://kpatlas.unaids.org/dashboard>. Retrieved Oct 31<sup>st</sup>, 2020.

<sup>10</sup> Ministry of Health. (2020). Draft Suriname HIV Epidemiological Profile, 2014 – 2019. Paramaribo: Suriname Government.

Figure 5: 90-90-90 HIV Cascade Suriname



Source 2016: National HIV Master data base, M&E Unit MOH 2017  
 Source 2019: MOH, Suriname Draft NSP 2021-2027

The 2018 BSS indicated that although respondents often were offered condoms and lubricants for free among MSM and TGW there was inconsistent use of condoms. One in every three MSM and Transgender woman reported that they did not use a condom the last time they had anal sex and 20% of MSM and Transgender woman sex workers reported that they did not use a condom during their most recent sexual intercourse. In contrast, FSW reported 96% consistent condom use with clients and 98% use of a condom during the last time they had vaginal sex.<sup>11</sup>

### 3.1.2 Health System Governance

The Ministry of Health is responsible for provision, regulation and finance of health. The Bureau of Public Health (BOG, for its Dutch acronym) is responsible for the public health programs, including environmental health, sanitation and surveillance, and also operates a public health laboratory.

In Suriname, the government provides health care through subsidized governmental and non-governmental health care providers. On the level of primary health care these are the Regional Health Services (RGD), a state-owned foundation, and the Medical Mission Primary Health Care Suriname (Medical Mission PHCS), a faith-based foundation. The RGD provides primary health care through 63 clinics to the population in the coastal area (Paramaribo included) classified as poor or near poor by the Ministry of Social Affairs, and to some of the clients insured by the State Health Insurance Fund (SZF), who choose to visit RGD clinics for health care, usually because of logistical reasons. The Medical Mission provides primary health care through 57 clinics covering the approximately 60,000 people living in the interior. The organization is financed by the Ministry of Health when it concerns the working expense. Additional costs are financed by projects, funded by donors.<sup>12</sup> The Medical Mission PHCS works with staff that originates from the interior, who after secondary school education are offered a certified 4-year training to become a health care assistant. These healthcare workers live in the communities, work with protocols and are in radio contact with each other, the head post in the region and the medical doctor assigned to that specific region. This physician is

<sup>11</sup> Ministry of Health. (2020). Draft Suriname HIV Epidemiological Profile, 2014 – 2019. Paramaribo: Suriname Government.

<sup>12</sup> <https://www.medischezending.sr/mz>

present in the area 3 out of 4 weeks a month. When not in the region radio contact is made with the headquarters of the Medical Mission PHCS<sup>13</sup>. In addition, primary care is also provided by approximately 180 private General Practitioners (GPs) who are registered at the Ministry of Health and provide services mostly in the urban and not too distant rural districts of Paramaribo, Commewijne, Wanica and Para.

On the secondary and tertiary health care level, the Ministry of Health operates two general and one psychiatric hospital in Paramaribo and a district hospital in the western coastal district of Nickerie. These are the Academic Hospital (AZP), the 's Lands Hospital (s'LH), a psychiatric hospital (PCS) and the regional district hospital recently renamed as Mungra Medisch Centrum (MMC), respectively, of which s'LH is well known for its focus on Mother and Child Care. In addition, there are 2 private hospitals, Diakonessen Hospital and St. Vincentius Hospital, in Paramaribo<sup>14</sup>.

### 3.1.3 HIV and TB response

The National AIDS Response in Suriname is coordinated by the Ministry of Health, and engages public, private and civil society stakeholders. Within the ministry, the National Aids Program (NAP) is an operational unit for HIV with an HIV Focal Point, administrative support, a staff member responsible for condom distribution, a pharmacist, and a M&E position (currently vacant). Suriname's HIV program is guided by the National Strategic Plan 2014-2020 which has two goals: 1) Reduce new infections, and 2) improve the quality of life of PLHIV. To achieve these goals, all activities were targeted towards a) reduce the HIV transmission among key and vulnerable population groups (MSM, SW, youth and others) and in the general population; b) expand high quality-comprehensive HIV treatment, care and support; and c) eliminating Mother-To-Child transmission. The new National Strategic Plan (2021-2024) is being formulated at this time and will be completed early 2021.

The public health approach of the HIV program is supported by the Center of Excellence (COE), an expert center providing leadership in the treatment and care of PLHIV and providing primary care physicians and health workers with treatment expertise as well as performing operational research and guiding policy development.<sup>15</sup>

Although a National Prevention and Communication strategy for health exists, it has not been used to lead and coordinate the prevention activities. Prevention activities focusing on the general population and youth were only a few, and prevention activities for KP are mostly provided through NGO's with donor financing. Condoms are distributed by the National AIDS Program through their distribution center called Libi! which freely gives condoms to individuals but also to different types of organizations. NGO's provide information as well as counseling and testing targeting specific groups e.g. adolescents and youths and/or those vulnerable to contracting HIV among whom, sex workers, undocumented migrants and others. Condoms are distributed to health institutions, NGO's working

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<sup>13</sup> When someone has a health insurance with the SZF or one of the private insurance companies but works and/or lives in a remote area, he/she makes use of the RGD or MM clinics in that area, because private practitioners usually settle in the capital city or coastal area and not in remote areas

<sup>14</sup> Ministry of Health. (2014). National Strategic Plan for a Multi-sectoral Approach of HIV in Suriname, 2014 – 2020. Paramaribo: Suriname Government.

<sup>15</sup> Ministry of Health. (2014). National Strategic Plan for a Multi-sectoral Approach of HIV in Suriname, 2014 – 2020. Paramaribo: Suriname Government.

with KP, pharmacies, motels, etc.<sup>16</sup> The government is considering the introduction of self-tests, and PrEP is being rolled out, although Covid-19 pandemic halted the process.

Treatment and care for HIV is provided through primary and secondary health clinics. Treatment is free to all and financed with domestic funds.<sup>17</sup> In addition to primary and secondary health care clinics, NGO's play an important role in the linking diagnosed persons to care. As of January 2018, 'Test and Treat' was officially introduced in the country leading to a yearly increase in the number of PLHIV being treated. Ministry staff noted that in 2019 the combination of Tenofovir, Lamuvidine and Dolutogravir (TLD) was introduced in Suriname as the 1<sup>st</sup> line drug of choice, and as much as possible all newly enrolled patients (500 annually) received TLD, but treatment protocols are yet to be updated in 2020 to include TLD as 1<sup>st</sup> line treatment. PEP is provided and included in the guidelines. PLHIV can access psycho-social support through the "Peer Counselor" and "Buddy" systems and the "Health Navigator" system provided by CSOs and supported by the MoH and the LINKAGES project.

Procurement of HIV and TB medicines is done through the Drug Supply Company Suriname (Bedrijf Geneesmiddelen Voorziening Suriname - BGVS).<sup>18</sup> Forecasting is jointly performed by the MoH and BGVS through a collaborative process. Forecasting methods have been developed but other funding, administrative and coordination challenges still result in stock-outs.

The National Tuberculosis (TB) program (NTP) is housed in the Bureau of Public Health (BOG), the department of the MoH that coordinates preventive health care, supervises and executes programs that provide information on the distribution of diseases. As the Ministry of Health is responsible for Tuberculosis (TB) control and prevention in Suriname and it provides funding for TB through three mechanisms: the budget of the MoH reserved for the operationalization of the BOG; a special budget line to fight against HIV, TB and Malaria as well as until 2021 a grant from the Global Fund (GF). The health insurances pay for the costs of hospital care. The Government of Suriname covers the cost for diagnosis and treatment, including medication for TB and HIV.

The Central Laboratory at the BOG provides quality assurance to the network of laboratories performing TB microscopy.

TB patients are treated by pulmonologists and are admitted to the sanatorium of the Academic Hospital Paramaribo (AZP) when infectious. Outpatients are supported by DOT supporters (paid by the government) who ensure that patients take their medication daily and follow through with the full course of treatment. The NTP collaborates with government organizations (prisons), NGOs (Medical Mission), other civil society organizations (CSOs) and communities to increase TB awareness, early case detection and TB treatment adherence.<sup>19</sup>

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<sup>16</sup> Ministry of Health. (2020). Draft Suriname HIV Epidemiological Profile, 2014 – 2019. Paramaribo: Suriname Government.

<sup>17</sup> The MoH finances all HIV commodities and services. Insurance covers treatment and hospitalization for opportunistic infections and tests for clinical management of HIV -such as hematology and blood chemistry panels, but the government covers insurance premiums for those eligible for a subsidy, those younger than 18 and older than 65, and all government employees. (see finance section).

<sup>18</sup> The BGVS is the company that procures all drugs, reagents and commodities ordered and/or approved by the Government, according to a selection of "essential medicines" for the country. The company also imports pharmaceutical raw materials and medical consumables.

<sup>19</sup> Ministry of Health. (2018 Update). National strategic plan for tuberculosis control 2015 – 2020. Paramaribo: Suriname Government

Annex 2 describes in more detail the governance of the HIV response and its challenges. Table 1 summarize the main challenges faced by the HIV and TB responses, identified through the document review and field interviews.

Table 1: Challenges to the HIV and TB programs

Area	Challenges
<b>Prevention and Outreach</b>	<ul style="list-style-type: none"> <li>• Prevention activities focusing on the general population and youth were few</li> <li>• Halting of LINKAGES project-resulted in 50%-60% less KP persons reached</li> <li>• Insufficient communication between CSO's and MoH preclude a better response to KP</li> <li>• Stigma and discrimination are an important deterrent to testing and treatment</li> <li>• CD4 and Viral Load testing are a challenge in remote areas due to the need to ship samples to Paramaribo</li> </ul>
<b>Testing and linkage to care</b>	<ul style="list-style-type: none"> <li>• Only 59% of persons are being linked to care.</li> <li>• Nearly a third of persons have CD4 count less than 200 at time of diagnosis</li> <li>• Stocks-outs of ARV's deter testing, as persons and providers anticipate there will be no treatment</li> </ul>
<b>Treatment care and support</b>	<ul style="list-style-type: none"> <li>• Current stock-outs present the largest threat to treatment.</li> </ul>
<b>Procurement</b>	<ul style="list-style-type: none"> <li>• Lack of funds and timely disbursements result in recurring (imminent) stock-outs, especially of ARVs and CD4 tests.</li> <li>• Organizational and management challenges contribute to (imminent) stock-outs.</li> <li>• Current economic crisis and disruption to international supply chains tied to Covid-19 have substantially increased stock outs</li> <li>• HIV drugs are more subject to stock outs than TB</li> <li>• HIV prevention and communication strategy in 2018 has minimal focus on condom procurement and distribution policies</li> <li>• There is potential to decrease prices through PAHO Strategic Fund<sup>20</sup></li> </ul>
<b>Psychosocial care</b>	<ul style="list-style-type: none"> <li>• Provision of Psychosocial care is fragmented, with several uncoordinated actors providing heterogenous services</li> <li>• Psychosocial care is mostly funded by donors</li> </ul>
<b>Human resources</b>	<ul style="list-style-type: none"> <li>• The MoH is challenged by a high rate of attrition of staff.</li> </ul>

### 3.2 Financial landscape.

<sup>20</sup> Previous reviews suggested up to 2018 prices procured by Suriname were lower or equal to those procured through PAHO. However, Ministry officials recognize this is no longer the case.

### 3.2.1 Macroeconomic situation

Suriname is a small open economy, classified by the World Bank as an upper middle-income country. Growth, government revenue, and foreign reserves are highly dependent on gold, oil and bauxite extractive industries. These industries provide 90% of foreign reserves and 30% to 40% of government revenues<sup>21</sup>. This dependency on extractive industries makes Suriname highly vulnerable to external shocks and drops in commodity prices.

During the last two years Suriname had been recovering from a recession that was fueled by a drop of oil and gold prices, and the cessation of bauxite production<sup>22</sup>. In 2015 GDP contracted by 5.6%. The recession caused a shortage of foreign reserves and increase in debt. The shortage of resources coupled with monetary financing of the deficit resulted in inflation rates of 55% during 2016. Figure 2 illustrates the evolution of the main macroeconomic indicators.

In 2017 Suriname's growth recovered, the current account showed a surplus for the first time since 2012, and inflation halved. By 2018 recovery was well on its way and GDP was projected to grow 2.5% in 2020<sup>23</sup>. However, the most recent projections after the Covid-19 epidemic, suggest Suriname's economy will contract by 13.1% in 2020<sup>24</sup>. The fiscal deficit and debt have also increased sharply (4 and 63 percentage points of GDP, respectively), not only as a result of the Covid-19 economic contraction, but also due to substantial spending increases in 2019 incurred during the months leading up to the elections, financed in part through monetary policy.

The economic situation is expected to improve in 2021 (see Figure 2). Gold prices have recovered, but oil prices have reached new lows<sup>25</sup>. Three new gold mines are expected to open in the coming months, and a reform of the VAT is being pursued<sup>26</sup>. This coupled with a reduction of electricity subsidies, should provide a small respite to Suriname's economy. Nevertheless, foreign reserve imbalances, high debt and a large deficit are expected to continue in the short term, which means that the country faces a tight fiscal space to expand health investments, and limited foreign currency availability to import commodities -including all medicines-, purchase fuel, and service the debt.

There are structural factors that suggest that these imbalances may persist into the medium term. IMF analyses suggests that although important advances have been made to improve monetary management, further modernization is needed<sup>27</sup>. Additionally, there is an urgent need to improve fiscal financial management, continue moving towards better governance and transparency in the extractive industries, and strengthen banking and financial regulation. The debt service will continue to absorb a large share of government expenditure, but according to the Surinamese Economist Association<sup>28</sup> only two of the country's twenty-three of external and domestic loans taken out only in 2019 were used for production, further limiting the capacity to service the debt.

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<sup>21</sup> Khadan, J. (2018). *Development Challenges in Suriname*.

<sup>22</sup> Op. Cit.

<sup>23</sup> International Monetary Fund. (2019). *2019 ARTICLE IV CONSULTATION—PRESS RELEASE; STAFF REPORT; INFORMATIONAL ANNEX; AND STATEMENT BY THE EXECUTIVE DIRECTOR FOR SURINAME*.

<sup>24</sup> <https://www.imf.org/en/Countries/SUR>

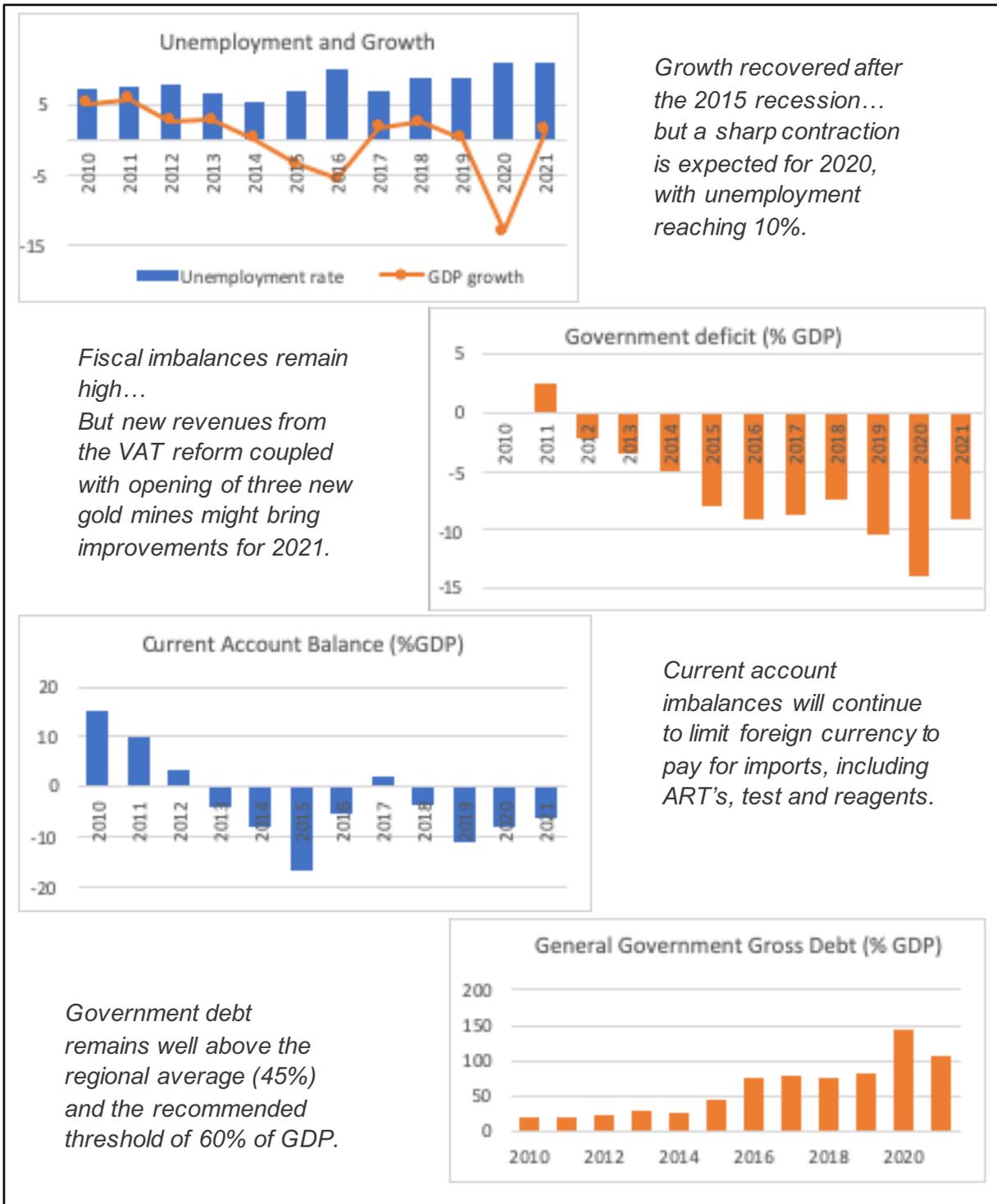
<sup>25</sup> <https://tradingeconomics.com/commodity/crude-oil>

<sup>26</sup> IMF (2019) Op. Cit.

<sup>27</sup> International Monetary Fund, *Suriname. 2019 ARTICLE IV CONSULTATION—PRESS RELEASE; STAFF REPORT; INFORMATIONAL ANNEX; AND STATEMENT BY THE EXECUTIVE DIRECTOR FOR SURINAME*, IMF (2019).

<sup>28</sup> Nieuwjaarsboodschap VES voorzitter <https://www.ves.sr/nieuwjaarsboodschap-ves-voorzitter-2020/> Retrieved July 14, 2020

Figure 2: Main macroeconomic indicators for Suriname 2010-2021



Source: The authors with data from IMF World Economic Outlook data, IMF (2019). Projected data: GDP, deficit, current account and debt: 2019-2021; Unemployment 2020-2021.

### 3.2.2 Health finance

Suriname spends 6.2% of GDP on health, a level on par with other countries in the Caribbean. Almost all health expenditure is financed with domestic resources (99%). Public funds provide for

58% of total domestic health expenditure, and out-of-pocket payments cover 26% -a level above the recommended WHO-threshold of 20%. The rest is covered with private funds, either from individual premiums or employer contributions. The National Health Accounts for 2016, report that health absorbs 13% of total government spending.

Table 2 shows the main health expenditure indicators.

*Table 2: Main Health finance indicators 2006-2017*

Indicators	2006	2011	2017
Current Health Expenditure (% GDP)	6.3	4.7	6.2
Current Health Expenditure per Capita (US\$)	327	393	339
Domestic Government Health Expenditure per Capita (US\$)	152	160	199
Domestic Health Expenditure as (% of Current Health Expenditure)	91.8	95.8	99.7
Domestic Public Health Expenditure (% Current Health Expenditure)	46.4	40.6	58.6
Out-of-pocket (% of Current Health Expenditure)	18.1	27.2	26.4
External Health Expenditure (% of Current Health Expenditure)	8.2	4.2	0.3

Suriname has a public national health system, with a combination of subsidized and provision of services, and mandatory health insurance. In 2014 the National Basic Health Insurance Act introduced compulsory health insurance in Suriname, obliging everyone in the country to be covered by at the least a 'Basic health care package'. This package covers all diseases on all health care levels, but to a maximum amount. There are two main insurance schemes: The State Health Insurance Foundation (SZF), and Private Insurances. The Ministry of Social Affairs and Housing (MSA), screens eligibility for subsidized access to the SZF,

The State Health Insurance Fund (SZF), insures between 70% to 76% of the population, including all government employees, the non-working citizens (under 16 and over 60 years) and the poor. The government covers the premium costs of the non-working citizens, and government employees. For working citizens, employees pay up to 50% of the health insurance premium, employers pay the other half.<sup>29,30</sup> The Ministry of Social Affairs and Housing (MSAH) administers the Health Card Program, which grants access to subsidized health insurance to those unable to pay (between 25% and 35% of those insured), and pays the premium to SZF on their behalf.<sup>31</sup> Two percent of the insured are covered by Private Insurances.<sup>32</sup> Despite the mandate 22% of the population remains uninsured<sup>33</sup>. If uninsured persons require urgent care, they can access subsidized health insurance for up to one year free of charge. SZF does not receive any premiums for those insured under the urgency

<sup>29</sup> [https://www.paho.org/salud-en-las-americas-2017/?page\\_id=15](https://www.paho.org/salud-en-las-americas-2017/?page_id=15), retrieved October 1st, 2020

<sup>30</sup> Country field interviews

<sup>31</sup> Jeetra Khadan, *Development Challenges in Suriname*, Country Department Caribbean Group (2018).

<sup>32</sup> TRA (2018) Op. Cit.

<sup>33</sup> TRA (2018) Op. Cit

mandate<sup>34</sup> but SZF monthly submits its costs to the government for reimbursement. Currently the implementation of the National Basic Health Insurance Act is being evaluated.

The government subsidizes two public primary care providers: The Regional Health Services, a state-owned foundation that provides services in Paramaribo and the coastal areas; and the Medical Mission, a faith-based NGO that provides care in the interior. In addition to government subsidies primary care providers submit invoices to SZF and private insurances for the services provided. Health care is free at the point of service for all those insured, the private insurance companies or the company they work for.

Capital investments are financed through loans or grants awarded to specific projects submitted by the respective health institution and/or the government.

### 3.2.3 HIV and TB Finance

Suriname finances all ART, and most HIV commodities – including condoms, and CD4 and diagnostic testing– from domestic resources. Testing and condoms are free to the general population (of which KP are not excluded) and paid by MoH. Targeted programs for key populations are provided by CSO and funded from donors and government funds. MoH finances all treatment and tests, and provides condoms for distribution through CSOs. Donors finance materials and human resources for CSOs' outreach programs, some test kits and condom distribution and some psychosocial services. HIV and TB treatment are not financed through health insurance, but rather directly by MoH.

Neither TB nor HIV treatments are covered by private insurance but paid directly by MoH and distributed by BVGS directly to providers or pharmacies. Other laboratory tests for clinical management of HIV -such as hematology and blood chemistry panels- are covered through health insurance, so the uninsured PLHIV need to pay for these tests out of pocket, which often becomes a barrier for care.

Table 3 shows the main financing indicators for HIV and TB. Total health expenditure in 2016 decreased by 30% compared to 2013 due to the economic crisis<sup>35</sup>. Despite of this contraction, the share of HIV on total health expenditure remained almost stable<sup>36</sup>. This increase managed to dampen the impact of the budget cuts on HIV expenditure. Moreover, the data suggests that Suriname increased the share of total spending financed from domestic resources, both from government and private sources.

National Health Accounts 2016 report a spending for HIV and STI of US\$4 million -2% of total current health expenditure<sup>37</sup>, of which donors financed 16%, government 68%. The NHA report does not include TB spending, but according to the TRA, in 2017, Suriname spent approximately US\$0.9

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<sup>34</sup> TRA (2018) Op. Cit

<sup>35</sup> Source for total health expenditure: NASA report to back up total health expenditure based on HIV and reported share of total expenditure and NHA for 2016.

<sup>36</sup> NASA accounts may include expenditure on other STI or family planning, while NHA HIV sub-account does not, which might explain the larger share reported for 2016. For comparability see Health Systems 20/20 Project, the Joint United Nations Program for HIV/AIDS (UNAIDS), and the World Health Organization (WHO). June 2009. *Linking NASA and NHA: Concepts and Mechanics*. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.

<sup>37</sup> Suriname Ministry of Health, *Suriname 2016 Health Accounts Report* (Paramaribo, Suriname, September 2018). pg 9

million on TB (0.4% of current health expenditure). Domestic sources funded 38.9% of the TB activities. Global Fund supported 50%, and other grants contributed the remaining 11.1%<sup>38</sup>.

For 2016 sixty-eight percent of HIV expenditure went to curative care, 12% to preventive, (below the UNAIDS target of 25% of HIV spending for prevention), and administration absorbed 9%<sup>39</sup>.

Table 3: Main HIV and TB financing indicators

	2012/2013	2016/2017
Total health expenditure on HIV (millions of US\$)	4.9	4
Current health expenditure devoted to HIV (%)	1.5	2
Current health expenditure devoted to TB (%)	-	0.9
<b>Funding sources HIV (%)</b>		
Government	60	68
Private*	2	16
Donors	38	16
<b>Funding sources TB (%)</b>		
Domestic sources	-	39%
GF	-	50%
Other grants	-	11%

Source: For HIV 2016 National Health Accounts, HIV 2013 TRA (2018) with data from NASA report 1012-2013. For TB TRA (2018).

\*Private sources include corporations and households

Two previous studies have estimated the financing needs to reach the 90-90-90 targets in 2020: the HIV Suriname Investment Case (2019)<sup>40</sup> and the Commodities Investment Framework report (2018)<sup>41</sup>. The investment case estimates resources needed in commodities, KP outreach programs and the corresponding management costs. The Commodities Investment report only estimates resources required to finance commodities (excluding condoms). Result are consistent between both studies: investment in commodities would need to increase between 81% and 84% from the 2017 level, while investment in total HIV expenditure would have to increase by 72% (See Figure 3). If the targets by 2030 were to reach 95-95-95, total expenditure would have to double from US\$1.5 million to US\$3 million. As noted in the Investment Case, this level of spending would still be lower than total spending seen in the period 2011-2013 (around US\$ 4 million). This might be explained by the fact that, as shown above, 2011-2013 was a period of steady GDP and government revenue growth, as well as larger flows of donor funding. This might suggest that if Suriname's economy recovers, fiscal space would be sufficient to finance investments required to reach the targets.

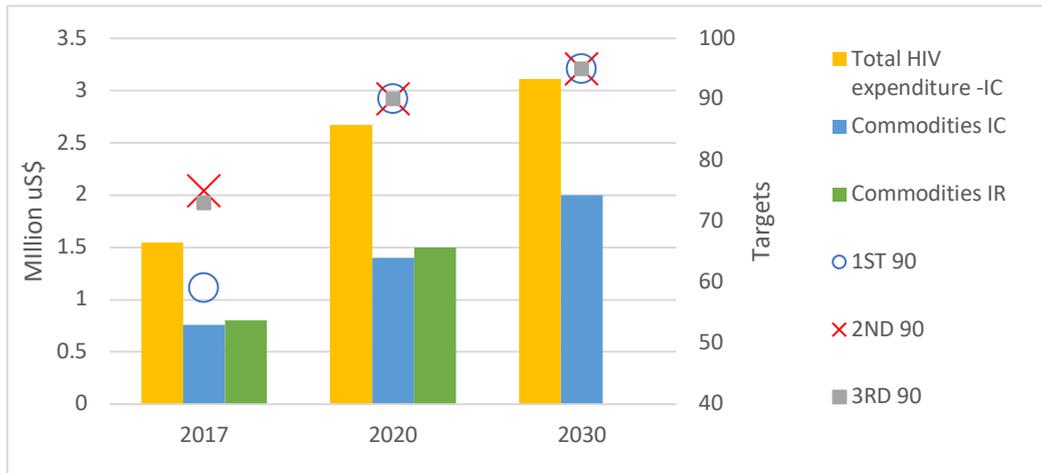
<sup>38</sup> ICF *Transition Readiness Assessment*. Op. Cit.

<sup>39</sup> Suriname Ministry of Health Accounts Op. Cit.

<sup>40</sup> Eline Korenromp et al., *HIV Suriname investment case. Final Report* (May 31 2019).

<sup>41</sup> PEPFAR, *90-90-90 strategy commodity investment framework*, US AID Global Health and Supply Chain Management, USAID (2018).

Figure 3: Resource needs to reach 90-90-90 targets by 2020 and advance towards the 95-95-95. Investment Case (IC) and Commodities Investment Report (IR)



### 3.2.4 GF expenditures on the HIV/TB responses

Between 2005 and 2019 Suriname has received five grants from the Global Fund to finance the HIV/TB response totaling close to US\$16.4 million<sup>42</sup>. The current active grant “*Joining Efforts: Supporting Vulnerable populations in the move towards 90-90-90*” (SUR-C-MOH), has two implementation periods. The first implementation period, which went from 2016-2019 has been completed, with total disbursements of US\$3.27 million (See the TRA for a detailed description of investments in the first implementation period). The second implementation period, which goes from 2019 to 2021, has total commitments of US\$1.4 million, of which US\$1.2 million have already been disbursed<sup>43</sup>. TB and HIV grants have focused on expanding prevention, testing and treatment for SW and their clients, MSM and youth, and increasing access to TB treatment and strengthening country diagnostic capacity.

According to the grant agreement the grant was aimed at<sup>44</sup>:

- Expanding HIV testing, counseling, and prevention outreach services for key affected populations (MSM, SW and adolescents in the interior) to more districts, including the rural interior and mining areas (for Female Sex Workers). This will also include a differentiation of the types of outreach to key affected populations to include new activities, including thematic events at private homes and safe spaces (in addition to clubs and cruising sites that have been the traditional focus of HIV outreach)
- Revisiting the delivery of HIV care with focus on increasing linkages to care, retention in care, and adherence to treatment by expanding psycho-social support services, scaling up peer counselors and buddies, and integrating HIV with other chronic diseases
- Protecting key populations’ rights by establishing a human rights desk, an inventory of human rights complaints, and the development of a human rights database

<sup>42</sup> ICF, *Suriname Transition Readiness Assessment. Final Report.*

<sup>43</sup> Source: Global Fund, <https://data.theglobalfund.org/investments/grant/SUR-C-MOH/2>. Retrieved October 18, 2020

<sup>44</sup> GF Grant agreement for Suriname

- Expanding TB screening contact tracing and DOTS, building on the success of the introduction of DOTS in 2011
- Improving the quality of TB laboratory and treatment services
- Improving data quality and M&E by strengthening skills, expanding human resources, and conducting strategic BSS
- Consolidation of the planning and management of HIV and TB programs for improved management of cases.

Table 4 shows the yearly distribution of funds among components and programs. Thirty-nine percent of the grant has been committed to HIV programs, most of which goes to comprehensive programs to SW and their clients (26%). TB care and prevention has absorbed 22% of commitments, health system strengthening (RSSH) 10%, and program management the remainder.

Table 4: Budget amounts by cost area of expenditure 2019-2021. Grant SUR-C-MOH

	2019	2020	2021	Total	Share of total (%)
<b>HIV</b>	281,187	248,652	174,399	704,238	39.04
Prevention for general population	3,110	1,037	1,037	5,184	0.29
Reduction of human rights barriers to HIV/TB services	10,602	8,292		18,894	1.05
Comprehensive programs for MSM	36,018	33,945	19,848	89,811	4.98
Comprehensive programs for SW and clients	173,889	173,857	130,118	477,864	26.49
Treatment, care and support	57,568	31,521	23,396	112,485	6.24
<b>RSSH</b>	113,354	62,229	6,411	181,994	10.09
Health Management and information systems and M&E	107,720	55,631	1,553	164,904	9.14
Health product management and systems	5,634		4,858	10,492	0.58
Integrated service delivery and quality improvement		6,598		6,598	0.37
Health sector and governance planning		14,995		14,995	0.83
<b>TB CARE AND PREVENTION</b>	302,648	136,656	75,749	515,053	28.55
<b>PROGRAM MANAGEMENT</b>	144,295	131,856	126,476	402,627	22.32
<b>TOTAL</b>	<b>841,484</b>	<b>579,393</b>	<b>383,035</b>	<b>1,803,912</b>	<b>100%</b>

Source: <https://data.theglobalfund.org/investments/grant/SUR-C-MOH/2>

RSSH: Resilient and Sustainable Systems for Health

GF is currently covering the costs for the coordination of the grant (Coordinator, Financial Manager and M&E officer), and pays for incentives for TB patients, and has financed Gene Xpert machines. GF co-finances consumables for GeneXpert TB tests, and for other microscopy and culture tests. GF funds training costs for the laboratory technicians, technical assistance for Central Lab (CL), planning and administration costs. The government pays, among other things, for medicines, tuberculin tests, all nurses and support staff of the NTP and CL, costs for consumables, DOT Supporters, certification and accreditation CL.

For the 2019-2021 grant the government had planned to absorb 50% of all donor funded activities for TB, and by 2020 all costs for TB prevention and care and a larger fraction of HIV donor funded activities.<sup>45</sup>

In 2020, Suriname accessed an additional US\$372,874 through the Global Fund Covid-19 Rapid Response mechanism to mitigate the impact of the pandemic on HIV/TB response, purchase additional Covid-19 testing and support community health system response. Additionally it reprogrammed US\$192,109 of grant fund to support the Covid-19 response.<sup>46</sup>

### 3.2.5 Funding from other development partners

Suriname's HIV and TB response has also benefited from other donors in the region. PEPFAR was active in Suriname with projects geared towards KPs. In 2015 it benefited from the HoPE initiative, focused on improved outcomes for KP through better care and treatment and promotion of a more enabling environment<sup>47</sup>. More recently, LINKAGES project supported CSOs with providing outreach and testing services, psychosocial support to PLHIV and linking diagnosed persons with care. Additionally, USAID has provided technical support on commodity investments and laboratory capacity building in the region<sup>48</sup>. However, PEPFAR last investment in the country ended with the last financing trench of LINKAGES project in 2019.

The Inter-American Development Bank provided a loan for Health Sector Reform Program in 2004 (US\$7.8 million), and more recently, approved a Service Delivery Improvement loan for US\$20 million, which is focused on "...financing strategies for NCD prevention and control and for malaria elimination, and integration of services for other priority communicable diseases within the Malaria Program"<sup>49</sup> (including HIV and STI)<sup>50,51</sup>

The 2018 loan has several synergies with the HIV and TB grants from GF, in two of its components: the component to Increase access to priority services of prevention and treatment for communicable diseases in mining population<sup>52</sup>, including HIV and Malaria; and a component for health information system strengthening. Additionally, the loan focuses on the implementation of Chronic Care Model for Chronic Diseases (including HIV) to improve accessibility and quality of clinical pathways for non-communicable diseases. Although this tranche focuses on Diabetes, overall it is expected to improve care in all chronic conditions, including HIV. Some of these investments are part of the co-financing commitments for the past and current GF grants.

PAHO and the Caribbean Public Health Agency-CARPHA, provide technical support to Suriname to develop tools to build country capacity to address infectious diseases and NCDs<sup>53</sup>. And PAHO has

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<sup>45</sup> Suriname Grant Commitment letter

<sup>46</sup> Global Fund: <https://www.theglobalfund.org/en/covid-19/>

<sup>47</sup> USAID: <https://2012-2017.usaid.gov/barbados/hiv/aid/>

<sup>48</sup> Including the 2018 commodity investment framework to reach 90-90-90 targets.

<sup>49</sup> GF. Suriname Loan document pgs. 12, 13.

<sup>50</sup> An earlier loan was approved in 1986 to improve Nickerie Hospital (7.8 million USD).

<sup>51</sup> As of December 14, 2020 the loan had been disbursed and the country had started implementing the Malaria component.

<sup>52</sup> The program includes studies of prevalence, behavior and migration patterns of mining population

<sup>53</sup> Inter-American Development Bank, *HEALTH SERVICES IMPROVEMENT PROJECT (SU-L1054) LOAN PROPOSAL* (Washington, D.C, July 31 2018).

supported the country through technical assistance in procurement and supply chain management, and UN provides technical support on health system strengthening, among others.

### 3.3 Community engagement in the responses

Civil Society Organizations (CSOs) play an important role in the HIV response in Suriname. There are nine CSO currently providing services for HIV. They provide services to key populations and hard to reach areas, including voluntary counseling and testing, support in navigating the health system, linkage to care, follow-up and retention services, and psychosocial support<sup>54</sup>. Some CSOs conduct advocacy actions, mostly in the form of education campaigns.

The Government of Suriname has a history of granting funds to CSOs, nongovernmental organizations (NGOs) and other community-based organizations to undertake activities and provide specific services to the community<sup>55</sup>. This takes the form of subsidies – as in the case of the Medical Mission- or financing for specific projects. Projects go to the specific ministry and are approved by the minister, rather than going through a competitive selection process, as would be the case for social contracting. Nevertheless, important progress has been achieved towards social contracting. Several studies have been advanced, including a mapping of CSOs;<sup>56</sup> a costing and inventory of the packages offered by CSOs, which includes an analysis of the cost-effectiveness of their services in relation to other programs in the Caribbean<sup>57</sup>; and a Social Contracting roll-out roadmap<sup>58,59</sup>. CSOs that were part of the LINKAGES Project were provided with training and now have improved systems for supporting PLHIV<sup>60</sup>. Moreover, the costing study found that the package of services offered by CSOs meet the minimum requirements for a comprehensive package of HIV prevention services as defined by WHO<sup>61</sup> and the mapping exercise found that some had the minimum governance structures in place<sup>62</sup>. Additionally, throughout the interviews there was a wide agreement, from both government and other actors in country about the important role that these organizations play in the HIV response, and the need to advance CSO contracting.

A clear Social Contracting Implementation Plan has been laid out. The plan defines three phases: Planning, preparation and implementation. To roll-out the planning stage the first step is for the MOH

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<sup>54</sup> Cardno Emerging Markets USA Ltd, *Suriname HIV Costing Activity Narrative Report* (17 April 2017). Pg 17.

<sup>55</sup> Ministry of Health. (2019). *Suriname Social Contracting Roadmap: A How-To Guide for Advancing Public Funding to Civil Society Organisations to Deliver Critical HIV Services*.

<sup>56</sup> Ministry of Health, & UNAIDS;. (2015). *Mapping van NGO's in de gezondheidssector*.

<sup>57</sup> Cardno Emerging Markets USA Ltd. (2017). *Suriname HIV Costing Activity Narrative Report*.

<sup>58</sup> Ministry of Health. (2019). *Suriname Social Contracting Implementation Plan for Sustaining HIV Services via Civil Society Organisations*.

<sup>59</sup> Suriname Ministry of Health, *Suriname Social Contracting Implementation Plan for Sustaining HIV Services via Civil Society Organisations*, Ministry of Health, (2019).

<sup>60</sup> Ansari Z. Ameen et al., *Final Evaluation and Situation and Response Analysis of the HIV NSP2014-2020. DRAFT* (2020).

<sup>61</sup> Cardno Emerging Markets USA Ltd, *Suriname HIV Costing Activity Narrative Report*.

<sup>62</sup> The mapping report included all CSOs providing social protection or health services not only those providing services for PLHIV. The summary of governance arrangements did not always distinguish between HIV related CSOs and other, but found that all CSOs studied had a board and had regular meetings. Some made had annual plan, annual financial or evaluation report. Several HIV-CSO's did not make reports. Most of the reports are geared towards donors, or to the Ministry of Social Affairs, when they receive subsidies from this body.

to establish a formal policy or position paper on SC, to name a focal point to act as SC manager, and to convene a planning team. According to interviews, a coordinator had been appointed to lead the implementation, but the COVID-19 emergency slowed down the process, and there was concern that the budget cuts would further slowdown the process. Once the position paper is completed the timeline for piloting the SC mechanisms should be reviewed and agreed upon. Stakeholders commented that some of the activities like advocacy and regulatory actions required few resources and could be prioritized in the face of reduced budgets. Agreement and final costing of the packages of services as well as capacity building both within the MoH and the CSO's are both crucial activities for the success of the pilot. These actions should be prioritized in the preparation phase but given that they might require more resources they could be good candidates for inclusion in the next grant request. Annex 3 presents the existing timeline, and comments on the degree of progress of the activities.

Although the MoH provides testing kits and condoms for prevention activities, CSO's in Suriname are heavily financed by donor resources. As donor resources have dwindled, the sustainability of CSO's is at considerable risk. Compounding the heavy reliance on donor funding, is the fact that most CSO's are weakly positioned to advocate for increased government funding, as this role has been overshadowed by the service provision role<sup>63</sup>.

Aside from donor funding and provision of commodities by MoH, some CSO's, have alternative funding sources, from providing services to private sectors and other government bodies. For example, New Beginnings' consultancy services to help the private sector create enabling environments and reduce stigma and discrimination, have a high demand<sup>64</sup>. This suggests that, although CSO are currently highly reliant on donor funding there is some space to progress towards self-sufficiency<sup>65</sup>.

Nevertheless, there are important challenges to SC. Despite some CSO's having received capacity building, during the interviews many CSO's expressed the need to strengthen their ability to develop a funding and resource mobilization strategy and improve their administrative capacity. Some expressed concern that their lack of experience in competitive and tendering processes might put them at a disadvantage to obtain SC's contracts. But there is agreement that the biggest challenge to social contracting is the reduced fiscal space. Most stakeholders interviewed feared that the economic crisis would push social contracting low in the list of funding priorities and believed that working with the MoF to secure funds for the pilot is a crucial first step for the viability of a pilot. Other CSOs feared that the situation among migrants and refugees would worsen, which would pose an additional challenge since the number of migrants among KP is significant<sup>66</sup>

CSO's also explained that due to serious social problems (lack of food, housing, employment) very often HIV or in general health issues are not a first priority for KP. As a consequence, uptake of HIV services by KP has been archived thanks to social support services, which have higher demand and act as entry point to HIV care. Currently social support services have not been costed, and until

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<sup>63</sup> ICF, *Suriname Transition Readiness Assessment. Final Report.*

<sup>64</sup> PANACAP, *Mobilizing Resources to Ensure a Sustainable Response to HIV/AIDS Case Study: New Beginnings/Chances for Life*, <https://pancap.org/pc/pcc/media/page/Chances-for-Life-case-study.pdf>.

<sup>65</sup> There is no current data as to the share of income derived from donors versus other sources. The mapping study of CSO's found that budgeting information was insufficient to document all sources of income.

<sup>66</sup> Field interviews with CSOs.

recently there was no discussion about including social support as part of the HIV package for SC. But members of CSO's agreed that with-out funding for social support services, their capacity to link and service KPs would be severely hampered.

## 4 Updating and Prioritizing the 2021 Sustainability Action Plan with the 2018 Transition Readiness Assessment and Work Plan

### 4.1 General overview of accomplishments

The 2019 TWP identified 4 strategic objectives for Suriname (see Annex 3 for detailed table):

- i) *Reduce barriers to access* HIV, TB and malaria services including reduction of stigma, discrimination, legal barriers for key and vulnerable populations, and gender inequality/based violence.
- ii) *Build political will* (across sectors) for increased and long-term domestic investments in the HIV, TB and malaria responses, including reaching key and vulnerable populations through social contracting).
- iii) *Move towards a more integrated (within sectors) and intersectoral response* for HIV, TB and malaria, including community and CSO's participation.
- iv) *Building and strengthening health and community systems* that support service delivery to support sustainable responses to HIV, TB and malaria by

#### 4.1.1 Strategic objective 1: Reducing barriers to access

To reduce barriers to access three strategies were identified: Increasing knowledge about barriers to access through data collection and research; developing a Migrant Strategy to increase access to services for migrants; and establishing a Human Rights Desk to document and address violations to human rights by all government and private actors. Only one of the 20 activities related to the above-mentioned strategies has been implemented. Progress on the remaining 19 has been uneven (we could not find information as to the current state of some activities, see Annex 3).

The *Human Rights Desk* development has stalled due to lack of agreement as to where it should be housed (MoH, other government body, or NGO's) and financed. Resources devoted to this activity have been reprogrammed and no further development of HR desk is expected. Since the HR desks was the starting point to collect data to understand barriers to access, understanding barriers to access among KPs has also stalled.

There has been little progress in developing the *Migrant Health Strategy*, although the government and the State Health Insurance foundation had agreed to provide migrants with a one-year health insurance at their point of entering the country. The start of the COVID-19 epidemic in Suriname in March 2020 halted activities initiating the implementation of this agreement. The IADB loan has an important component addressing some of these issues, including conducting studies of barriers faced by migrants to access services, as well as of the overall size and epidemiology of migrant populations. But at the time of writing of this report the loan had not been disbursed as the Government was reluctant to assume more debt and was revising all the debt situation.

The *Communication Strategy* to reduce stigma and discrimination has not been developed either, mainly due to human resources challenges. The exception are the trainings for health care workers

on specific issues that impact service delivery (STIs, stigma, mental health, transgender topics, etc.) for key and vulnerable populations, but stakeholders agreed that due to high turnover rates, these trainings need to be conducted on a regular basis to be effective.

#### 4.1.2 Strategic objective 2: Building political will for increased domestic investments

More progress has been achieved towards building political support for domestic investments for HIV and TB. This strategic objective included actions to increase advocacy and technical and administrative capacity; ensure cost and programmatic effectiveness/optimization of existing responses and resource allocation; and reengaging private and other government stakeholders in the disease responses. Of the 23 activities, 3 have been fully implemented, 4 are in progress and 3 have been deemed no longer relevant. The rest have not been implemented (we did not determine the stage of progress for 3 activities).

The investment case has been finalized and several studies addressing the effectiveness of government and NGO's interventions has been completed. Including a preliminary costing of CSO's services and an evaluation of the cost-effectiveness of these interventions, as well as some procurement and supply chain efficiency studies. The effectiveness of peer navigators and buddies' study is still pending. However, an advocacy strategy using all the results of these studies has yet to be developed. The TWP also included a review of whether CSO's could be involved in TB outreach programs, but MoH officials agree that with the possibilities of video-DOT (Directly Observed Therapy), this is no longer a relevant action. The use of video by phone or other video/computer equipment to observe tuberculosis (TB) patients taking their medications remotely is a flexible and less invasive method to support patients.

As part of the strategy to reengage stakeholders in the disease response, meetings with faith-based organizations groups have been organized with the support from PANCAP. However, coordination and joint work with other government stakeholders, and institutionalization and development of a more visible M&E system to track progress towards the goals has not yet been implemented.

#### 4.1.3 Strategic objective 3: Move towards a more integrated and intersectoral response

This strategic objective included strategies toward expanding prevention; improving coordination and integration within the health sector and CSO's; and improving linkage to care. Of the 22 activities proposed, 6 have been completed and 3 are currently in progress.

Regarding *prevention activities*, discussions to roll-out PrEP have started, but progress was stalled because of the Covid-19 epidemic and the economic situation. Self-testing is also being discussed. Both technologies have been included in the 2021-2024 NSP draft. The 2019 treatment guidelines have been updated to include Treat-All strategies, but according to MoH officials a new update is needed.

Activities to *integrate CSO's in the model of care* are progressing steadily. The *CSO contracting roadmap* has been developed, trainings to promote coordination between CSO's and national health service providers has been conducted and CSO's received training through the LINKAGES project to improve relations with the KP's they serve. The definition of the package of services that will be used for SC has yet to be completed, although preliminary studies are already underway.

Among the strategies to improve *linkage to care*, only 2 of the 11 activities have been completed:

absorption by Government of TB personal funded by GF funds has been completed and the mapping of NGO's support services to KPs.

#### 4.1.4 Strategic objective 4: Building and strengthening health and community systems

This strategic objective involved actions to improve supply chain management to prevent stock-outs; strengthen information systems for decision making; addressing human resource challenges both in retention and technical capacity; strengthen laboratories; and promoting the involvement of CSO's in decision making. A total of 38 activities were included, of which 7 had been completed and 12 were being implemented (no information for 5 activities, the rest have not started).

Forecasting for *Supply chain management* has been strengthened and is operational, but still needs to be formalized by the establishment of SOP manuals. An electronic tracking system for condoms demand, supply, and distribution was implemented, but its extension to other commodities and to ARV's, is still pending. Procurement through PAHO Strategic Fund (SF) is progressing and recently certain ARV's have been procured through the fund. The country is also working towards having a system to compare the SF prices with prices procured from other sources. Two limitations to expand procurement through PAHO SF were identified through the filed interviews: The first is that PAHO requires pre-payment, which becomes a challenge given the irregularities of disbursements of funds from MoF. The second is that actors perceive that procurement through PAHO SF is protracted and burdensome, and given the insufficiency of human resources, other procurement mechanisms end up being favored. Up until 2017, Suriname paid prices equivalent to those that could be obtained through PAHO SF,<sup>67</sup> but since 2019 price gaps have widened making the SF a better alternative.

Important progress has been achieved towards improved *information systems*. A master data set has been developed that permits cascade tracking, and training in standards and techniques to assure the quality of the data have been finalized. Previous problems with unique patient identifier and deduplication have been addressed. The system is used for decision making, but more strategic dissemination of results is still needed to improve advocacy and coordination. Some of the personnel devoted to inputting and managing data are still financed by GF grants.

Activities to address *human resource* (HR) challenges have progressed partially. A system to track HR trainings is operational. Other activities included in the TWP have not been implemented, but the HR challenges have been identified as a priority in the coming NSP.

*Lab strengthening* activities have progressed significantly. MoH oversight of labs and improved quality control, assurance and accountability activities are being implemented; a technical collaboration with the Netherlands National Institute for Public Health (RIVM for its acronym in Dutch) to act as supranational reference laboratory has been successfully established; and decentralization of sputum collection through collaboration with MM and the RGD has been established.

No activities towards *promoting involvement of CSO's in decision making* have been started.

## 4.2 Key transition and sustainability risks

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<sup>67</sup> Cico Altea, Stephen Musau, and Jhana McGaugh, *Suriname HIV Commodities Procurement and Supply Chain Management Efficiency Study.*, Health Finance & Governance Project (Bethesda, MD: Abt Associates Inc., 2017).

Risks identified in the TRA are still valid. However, new procurement and supply chain challenges have surfaced due to disruptions in global supply chains. The economic crisis has deepened, both because of the pandemic, but also due to increased spending and debt tied to the electoral cycles. Technical capacity within the ministry was debilitating before the current government, but the change in government poses an additional challenge to knowledge retention as several staff have left MoH posts. Additionally, there has been little progress in addressing stigma and discrimination in the community and to a lesser degree in the health system. As mentioned before, some progress has been made in sanitization of health personnel, which needs to be maintained through recurrent trainings. But there is still much progress to gain. As highlighted in the TRA, stigma and discrimination pose significant barriers to treatment and testing.

Table 5: Risks for sustainability and transition

Risk identified by the Transition Readiness Assessment (TRA) Report	Current state of the risk and new emerging risks since the TRA
Constrained fiscal space <ul style="list-style-type: none"> <li>• Steep economic recession</li> <li>• Withdrawal of donor funding</li> <li>• Exchange rate issues means funds for HIV/TB are not being disbursed</li> </ul>	Economic crisis has deepened <ul style="list-style-type: none"> <li>• Increase in fiscal deficit and debt. Expected contraction of 4.9% of GDP vs. forecast of 2.5% growth</li> <li>• Withdrawal of donor funding</li> <li>• Exchange rate has been depreciated but probably not enough</li> </ul>
Dependency of community engagement strategies on external fund <ul style="list-style-type: none"> <li>• Heavily reliant on donor funding</li> <li>• Conduct outreach and provide testing services to key populations - at risk of not being sustained</li> <li>• Advocacy and oversight role has been somewhat overshadowed.</li> </ul>	Still present and relevant
<ul style="list-style-type: none"> <li>• TB mostly donor financed</li> </ul>	<ul style="list-style-type: none"> <li>• Previous positions funded by GF have been absorbed, but important budget lines for commodities for labs are still financed by GF (see finance section)</li> </ul>
<ul style="list-style-type: none"> <li>• Stigma and discrimination are important barriers to access testing and training</li> </ul>	<ul style="list-style-type: none"> <li>• Stigma and discrimination are still important barriers to access testing and training</li> </ul>
Technical capacity was not identified as a priority risk in the TRA	<ul style="list-style-type: none"> <li>• Technical capacity within the Ministry has been consistently weakening for several years due to high turnover, and difficulty retaining personnel.</li> <li>• Several staff members have left the MoH and some positions remain vacant.</li> </ul>

#### 4.3 Priorities for action and recommended actions for 2021-2025

Six strategic goals for sustainability were identified through the stakeholder consultations and

validation exercises (see annex 4).<sup>68</sup> Based on document reviews, internal discussions, and consultation with GF staff, Pharos narrowed down the list to four strategic goals. The first, is *developing a funding strategy to increase resources for HIV/TB programs needed to reach the 90-90-90 targets and progress towards the 95-95-95 targets*. The second is *eliminating stock-outs of HIV commodities*. The third strategic goal is *rolling-out social contracting* and the fourth is *finding approximately 3,400 PLHIV that are unaware of their status*.

Two other strategic goals were identified through the stakeholder consultations: *strengthening coordination, communication, and organizational capacity of the HIV program*, and *continuing to develop and institutionalize the HIV information system*. Both activities are related to capacity building and administrative strengthening. Both are still priority goals, in fact, the need to strengthen the HIV program was identified unanimously by all the stakeholders interviewed as a priority goal for sustainability. However, these issues are being addressed in the NSP. Therefore, in an effort to complement interventions and avoid duplication, they have not been prioritized for the Sustainability Action Plan.

#### 4.3.1 Develop a funding strategy to increase domestic HIV/TB spending

The largest risk for a sustainable transition is the lack of a continuous and secure flow of funds for HIV. Therefore, it is imperative to prioritize the development of a clear explicit funding strategy. The funding strategy should identify and quantify the sources of finance to increase annual spending in the amount needed to reach the 90-90-90 targets and advance towards the 95-95-95 targets. According to the Investment Case Study and the Commodities Report, to reach the 90-90-90 this would require an increase of US\$1.1 million, and advancing towards the 95-95-95 would require an additional increase of US\$0.4 million<sup>69</sup>. Using the Investment Case annual spending growth required to reach the 90-90-90 targets, and assuming the targets are reached by 2024, spending should be increased by at least US\$1.4 million by 2024. These are the minimum increase in programmatic resources needed in order to reach key populations with prevention, testing, and treatment.

These investments will avert 1,850 new infections, which will not only result in better health status and quality of life for many, but will translate in lower health and health insurance costs for the government, less social assistance requirements, and will prevent loss of productivity due to ill health of those infected. Similarly, 1,396 deaths will be averted.

Developing the funding strategy can be achieved through national stakeholder engagement with the support of technical assistance. The technical assistance project should focus on explicitly identifying the funding sources to close the 1.4 million gap. In particular, the technical assistance project should identify the sources from

- 1) The potential sources from the private sector, aided by the mapping of private sector philanthropies (see below).

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<sup>68</sup> The six areas identified through stakeholder consultations were i) Increasing domestic financing sources, identify sources of savings and improve efficiency in the current use of resources, ii) eliminating HIV commodity stock-outs and wastage due to expired medication, iii) Strengthen coordination, communication, and organizational capacity within MoH HIV program iv) Rolling-out social contracting, v) continuing to strengthen information systems and vi) improving testing and care. Annex 4 lists the six key strategic goals from the TWP that were identified through stakeholder consultations as priorities for a sustainable transition, and the actions that were deemed important to achieve the goal.

<sup>69</sup> Investment Case (2019). Baseline expenditure in 2017 is US\$1.5 million.

- 2) Synergies with investments from other international donors. For example, countries with a strong HIV/TB programs were able to leverage testing and tracing teams, outreach programs and laboratory capacity to better counter the Covid-19 epidemic. There is a strong argument for using resources from grant for disaster resilience to invest in these areas. The HIV response can benefit too from grants strengthening chronic conditions service provision. There are important synergies with the current IDB loan, which should be explicitly incorporated in the financing strategy.
- 3) Other international donors. The Dutch government in particular is the fourth largest funder of HIV programs geared towards key populations, and 10% of all funding for KP comes from private philanthropies. Once the TA has identified these donors, the MoH should make a formal request to the MoF to support grant seeking.
- 4) Potential savings from pooled procurement as well as savings identified through other previous studies, including efficiency of peer navigators and buddies study (included in current grant).
- 5) Using the results from technical assistance project included in previous grant to analyze which services related to HIV, TB and malaria can be targeted for cost recovery, identify potential sources of income through this route.
- 6) Potential income from financing HIV commodities and treatment through health insurance (see below).

The TWP identified the need to construct an advocacy strategy using the investment case to increase domestic public spending. The investment case has been finalized, but the development of the advocacy strategy, which was included as part of the current grant, has not yet been implemented. Using resources from the past grant the advocacy strategy should be developed during 2021, before the end of this grant period. The advocacy strategy should include identifying parliament members that are willing to advocate for increased investments, as well as meetings with MoF to make a clear economic case for increasing expenditure in HIV, and to guarantee the timely disbursement of funds for the procurement of HIV commodities. Joint advocacy efforts with civil society will help make the case for these investments. The current grant includes resources to develop a white paper stating the position of civil society and its support for increased resources for HIV. The current grant includes resources to support the white paper, and every effort should be made to complete this work before the end of 2021. The Global Fund can support the advocacy strategy by participating in the meetings with high level stakeholders. Activities to implement the advocacy strategy can be supported with resources from the next grant.

A second set of actions should include actions to increase private funding, by incorporating actions by the private sector in the HIV response. Pharos carried out a preliminary exploration to understand the viability of this strategy. According to the field interviews, the mining companies are already collaborating with the Malaria Program and have expressed interest in collaborating with activities geared towards the wellbeing of their workforce, and likely, more broadly with activities geared towards the wellbeing of the communities where they operate. Additionally, the Suriname Business Coalition against HIV groups a number of private businesses with interest in supporting the HIV response. The Business Coalition is a member of the C-CCM and has previously been a recipient of

PEPFAR grants<sup>70</sup>. As such, it could help jumpstart a wider approach with a stronger integration to the NSP strategies.

Finally, given that 72% of Suriname’s population is insured, it is worth exploring whether it is possible to including some or all of the HIV commodities and services in the benefit package. To finance this inclusion in the benefit package, an increase in the premium would be needed. The increase in the premium can be shared between the government and the private sector. Financing HIV services and commodities through health insurance has the additional advantage of providing a flow of funds that is less vulnerable to the MoH budgetary fluctuations. However, there are also risks and political challenges associated with changing this financing scheme, including the need to guarantee HIV treatment and care to the uninsured PLHIV. Moreover, a large share of the income from premiums to the National Insurance Foundation comes from government funds, both through the premiums they pay for their employees and via the subsidies they provide to those with limited ability to pay, the young and those older than 65. Therefore, a detailed feasibility study should be carried out to determine the convenience of modifying the financing mechanisms of HIV treatment and care. Table 6 lists the actions and activities suggested to achieve this strategy.

Table 6 *Develop a funding strategy to increase domestic spending for HIV/TB programs*

Actions	Activities
<p><b>Explicitly identify and quantify sources of funding to reach the goal of increasing annual spending, by US\$1.4 million.</b></p>	<ul style="list-style-type: none"> <li>• TA to identify funding sources including:</li> <li>• Sources from the strategies suggested below (funding from MoH, private sector, Health Insurance),</li> <li>• Synergies with other development partners’ projects (particularly IADB Health system strengthening and UN Information systems).</li> <li>• Identify efficiency gains from lower prices accessed through pooled procurement</li> <li>• <u>Using/Finishing</u> studies to identify efficiency savings from peer and navigators/budies and novel testing strategies</li> <li>• Explore jointly with MoF -through a formal request- other sources of international funding, particularly re-engage Duch government and Philanthropies</li> </ul>
<p><b>Advocacy strategy to increase public domestic investments</b></p>	<ul style="list-style-type: none"> <li>• Develop advocacy strategy with funds assigned in the past grant</li> <li>• Conduct 3 high level advocacy meetings (MoF, group of parliamentarians, other ministries)</li> <li>• Sign letter of compromise on fund increase for next 4 years based on amount identified in the technical assistance project</li> </ul>
<p><b>Develop innovative funding approaches to increase participation of private sector in promotion, and testing activities.</b></p>	<ul style="list-style-type: none"> <li>• Map social corporate responsibility activities in Suriname, with the help of the C-CCM and the Suriname Business Coalition against HIV</li> <li>• Identify candidate industries/companies, and make an initial approach</li> <li>• Design jointly with the private sector a model of involvement and deployment of activities funded by the private sector (e.j. twice a year national campaign, HIV/TB day, employee programs, etc.)</li> <li>• Mining companies can be approached as a separate group, given they already have activities.</li> </ul>

<sup>70</sup> The Coalition was a recipient in 2017 of a grant directed towards programs for MSM. <https://sr.usembassy.gov/us-ambassador-signs-pepfar-small-grants-fy2017-two-recipients/>

<b>Identify potential for financing of HIV services and commodities through health insurance</b>	<ul style="list-style-type: none"> <li>• Finish technical assistance project included in previous grant to analyze which services related to HIV, TB and malaria can be targeted for cost recovery</li> <li>• Technical assistance (TA) to: <ul style="list-style-type: none"> <li>• Determine if financing some or all of the services and commodities for HIV through Health insurance has the potential to increase available funds</li> <li>• Evaluate alternative funding schemes to increase resources available for HIV. TA should include mechanism to guarantee coverage of uninsured PLHIV, as well as political feasibility and budget impact analysis.</li> </ul> </li> </ul>
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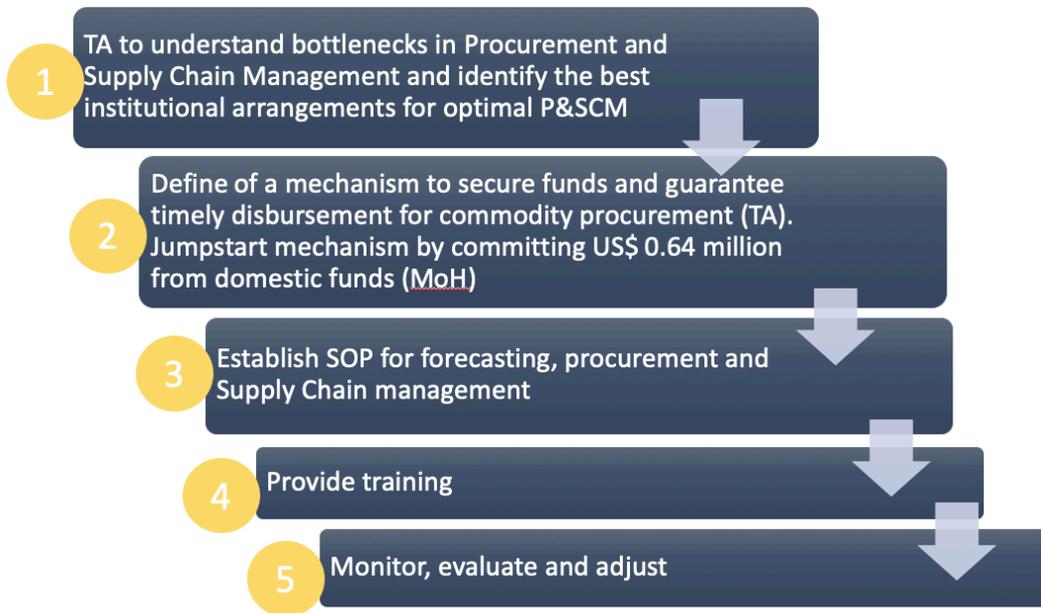
#### 4.3.2 Towards zero wastage and stock-outs of HIV commodities

One of the largest risks identified during the stakeholder meetings was HIV commodity stock-outs. Although the stock-outs have been more severe as a result of the current economic and public health crisis, they seem to be more a result of recurring events due to structural factors and inefficiencies in the procurement and supply chain management.

The country has received technical assistance for forecasting commodity needs, and significant advances have been made. Currently the MoH has an established and systematic forecasting process. As expressed by one stakeholder “there are still some things that can be improved, but the system is working well”. Nevertheless, the process needs to be institutionalized through the establishment of SOP guides and regulations. Additionally, other aspects of the supply chain management still need to be improved, including securing the funds for purchasing, advancing pooled procurement strategies and more efficient distribution of commodities.

The country would benefit from technical assistance to identify bottlenecks and inefficiencies in procurement and supply chain management. Currently PAHO and UN are providing technical assistance and will continue to do so in the coming months. Nevertheless, Table 7 lists recommend actions to address stockouts and inefficiencies. There is an urgent need to design a mechanism to secure funding for ARV’s and other HIV commodities (whether through health insurance or by direct government funding), as well as to secure the timely disbursement of funds. This is a crucial action to achieve a sustainable transition. One such mechanism could be the establishment of an emergency fund to draw from when the lack of timely disbursements poses an imminent risk of stock-outs. The fund would be replenished once the funds are disbursed. Alternatively, a special account administered by MoH or BGVS can be established by law. The law can restrict the use of the funds in the account exclusively for the purchase ARV’s and other HIV commodities when delays in disbursements generate imminent stock-outs. The law should state the mechanism and timeline to replenish the funds. A technical assistance project could define the amount of resources needed, sources to finance the initial funding, the feasibility and regulatory requirements to implement the mechanism, and propose the mode of administration, whether through a fiduciary arrangement or other arrangement.

Table 7: Towards zero wastage and stock-outs of HIV commodities



#### 4.3.3 Accelerate the Roll-out of Social contracting

CSOs are heavily funded by donors and provide an important share of services to KP and other PLHIV. Rolling out social contracting to maintain the gains in reaching KPs is a priority for a sustainable transition. As mentioned before, Suriname has made important progress towards social contracting, and there is a clear roadmap. The GF grant for the period ending in 2021 did not include activities to roll-out SC. The next grant should give priority to this strategy, with Suriname co-financing the initial stages, through the co-financing requirements and the GF grant financing the first pilot and CSO's trainings. Table 8 lists the actions to roll-out Social Contracting. More detailed activities are spelled out in the Social Contracting Road Map and are not repeated here. One of the risks identified by the TWP was that CSO's role in advocacy has been overshadowed by their service provision role. CSOs play a crucial role as advocates for KP and play a crucial role as service providers. CSO groups interviewed identified the need for capacity building for strategic discussions and policy engagement. The need for CSO's to engage in strategic and policy discussions will only increase as SC gains tractions. The TWP had previously identified the need to strengthen CSO's advocacy role and proposes some activities to achieve this goal. The SC roadmap also mentions strengthening the advocacy role as one of the steps in CSO's capacity building processes, but does not detail the activities to achieve this goal. Table 9 lists the activities from the TWP. These activities should be part of the technical assistance project to strengthen capacity of CSO's. In a separate document we provide the TOR's for such a TA. Table 9: Strategies and activities identified in the TWP to strengthen advocacy capacity of CSO's

Table 8: Actions to roll-out Social Contracting



4.3.4

Table 9: Strategies and activities identified in the TWP to strengthen advocacy capacity of CSO’s

<b>Strategy 4.5.1:</b> Strengthen the partnerships and alliances between CSOs	<b>4.5.1.a:</b> Through the organization of CSO networks or Umbrella CSOs facilitate the ability of CSOs to advocate the needs of affected, key and vulnerable populations in a holistic manner.
	<b>4.5.1.b:</b> Support CSOs to develop strategies and mechanisms to ensure their views are appropriately and accurately reflected in the national decision making
<b>Strategy 4.5.2:</b> Strengthen the capacity of CSOs to engage in strategic discussions and decision making	<b>4.5.2.a</b> Develop a plan to increase the capacity of CSO Networks and CSOs in five key areas: - Strategic planning and CSO management - Conducting research and policy analysis - Monitoring and evaluation - Advocacy and political engagement
	<b>4.5.2.b:</b> Develop a plan and protocols for civil society to develop common positions based on strategic information and community/constituency needs

Source: Suriname Transition Workplan (2019)

4.3.5 Find 3,400 undiagnosed PLHIV

As discussed in section 1 Suriname has made important progress in the second and third nineties of the cascade. However, diagnosing PLHIV is still lagging. Establishing a sustainable strategy to increase diagnosis is paramount for a successful transition. The TWP identified the need to incorporate self-testing into the menu of strategies to increase diagnosis. Self-testing has proven to

be a successful strategy to increase testing up-take.<sup>71</sup> A feasibility study was included in the current grant but has not been completed yet, as the country has been unable to find a consultant interested in the project, and the process has been delayed due to Covid-19.

Completing the feasibility study with the resources from the current grant is critical to advance towards a pilot. The grant also included a small pilot for MSM, which should also be finalized before the next funding period. These two activities from the current grant will set the basis for a broader pilot financed with the next transition grant. The pilot should differentiate strategies by population sub-groups (KP, general, age, etc.). Resources from the next grant can be devoted to co-finance the design and deployment of the self-test pilot. Stakeholders expressed concerns regarding the resources needed for the self-test kits, given the tight fiscal situation. One possibility is that resources from the next grant are used to finance the test kits for the pilot. As Suriname's economic situation improves, the country can move from the pilot phase to full implementation and assume the cost of the kits; this can be part of the country's future co-financing commitments.

Additionally, stakeholders consistently identified stigma and discrimination as an important barrier to testing. According to stakeholders, communication and education campaigns have been successful in the past in improving behavior and knowledge. Empirical evidence also shows that communication campaigns, if designed appropriately, can increase testing, condom use and knowledge of transmission modes. However, in Suriname the campaigns have been sporadic, and gains have been diluted with time. According to stakeholders interviewed, a broader communication and health literacy strategy is needed. The campaign should be focused on providing knowledge about HIV to reduce misinformation, and stigma and discrimination. The results from the study addressing barriers to case finding, which is included as part of the current grant should be finalized and can inform the design of a communication and health literacy campaign, which should be a permanent strategy of the HIV response, rather than a one-off activity<sup>72</sup>. The results from the *Lespeki mi* qualitative study will also prove useful. Some stakeholders believed that the campaign should be addressed to the general population, in order to reach a broader audience. They also consider that an important group of KP that are immersed in the community are not reached through targeted KP activities. For example, thirteen percent of MSM reported being in a stable relationship with a woman. Nevertheless, it is also important to target at least some messages to KP. For example, in the 2018-2019 biologic and behavioral survey, only 32% of female SW answered all the questions regarding modes of transmission correctly. One way to reach a wider audience is by packaging the promotion and prevention campaign of HIV with the promotion and prevention of other infectious disease or chronic activities. This will help to broaden its public and can generate savings by sharing resources with other MoH projects and activities.

A technical assistance project should inform the design of the communication campaign using best practices, evidence-based approaches and audience segmentation. We provide the terms of reference for one such TA project. The objective of the technical assistance project should be to 1) identify barriers, enablers and influencers for the uptake of prevention and testing, for improved better knowledge about modes of transmission and treatment, and lower stigma and discrimination towards PLHIV, 2) identify using best practice approaches and available evidence the mode of delivery of the communication campaign, considering audience segmentation, social marketing approaches and 'edutainment', among others and, 3) identify the convenience of grouping the HIV communication

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<sup>71</sup> Citation

<sup>72</sup> The current grant secured \$2,073 to identify barriers to case finding

campaign within a health literacy campaign with other chronic or infectious diseases, in terms of effectiveness in reaching the desired audience, and potential savings.

Finally, the TWP identified the need to address violations to human rights through the establishment of an HR desk that would collect information on violations from all actors and help seek redress. The past grant had secured resources to finance the HR desk. As mentioned before, the development of the HR desk stalled due to lack of agreement as to how to distribute responsibilities and accountability. Funds were re-programmed for the Covid-19 response.

An alternative to the HR desk, would be to evaluate the current redress system of the judicial system, to improve the current system and integrate in a formal way the services provided by CSO's as facilitators of the redress process for KP. This work can be led by a working group comprised of CSO's, C-CCM members, and MoH. Resources from the grant can be used to finance, legal consultations and project management or consulting support. The result of the working group should be a clear path of redress, and a clear picture of the legal or normative change required to make it viable.

Table 10: Find 3,400 undiagnosed PLHIV

Actions	Activities
<b>Address stigma and discrimination</b>	Establish working group to evaluate and formalize mechanism of redress within the existing justice system, and formally incorporate services provided by CSO's
	Design and implement a strategy for sustained Health literacy and Stigma and discrimination
<b>Roll-out self-testing</b>	Finish viability study included in current grant
	Design a pilot differentiating population subgroups and setting targets
	Roll-out pilot

#### 4.4 Sustainability Action Plan: costing and responsibilities

Table 11 presents an approximate costing for the activities recommended in this Sustainability Action Plan and suggested responsible partners. The costing suggest that the activities recommended require close to US\$344,000, of which the coming grant could finance around 60% and the rest could be financed by the Suriname or other development partners as part of the co-financing requirements. Annex

Table 11: Responsibilities and expected costs

Strategies and actions	Responsible	total cost US\$	Suggested financing source			Implementation period
			Grant request	MoH	Other partners	
<b>1. Develop a funding strategy to increase resources for HIV/TB programs (US\$1.4 by 2024)</b>						
<b>1.1 Increase support for domestic funding for HIV/TB</b>						
Develop high level advocacy strategy using economic studies and joint white paper with civil society, with support from GF and other development partners.	MOH	5,328	Included in GF past grant	100% Admin costs	-	2021
Involve private sector in the response : Map Corporate social responsibility efforts and create joint programs to foster private initiatives, with separate strategy for mining companies	MOH, C-CCM	8,368	80%	20%	-	2022-2024
<b>1.2 Capitalize on other donor funded initiatives</b>						
Make a plan to capitalize on technical assistance from multilateral organizations for health system strengthening, pandemic preparedness and chronic disease management (joint working group with other units in MoH and MoF).	MOH	5,208	100%	0%	-	2021 (possible reprogramming of current grant)
Make a formal request to the MoF to identify grants and funds for HIV.		HR administrative and coordination costs	0%	100%	-	2021
<b>1.3 Explicitly identify financing sources to increase domestic funds by US\$1.4m by 2024 for the HIV/TB response</b>						
Technical Assistance project to identify funding sources and savings from improved efficiency. Including potential of financing HIV TB services and commodities through health insurance	MOH	34,914	90%	10%	-	2022-2024
<b>2. Towards zero wastage and stock-outs of HIV commodities</b>						
Technical Assistance to understand bottlenecks in Procurement and Supply Chain Management and identify the best institutional arrangements for optimal P&SCM	MOH with support from PAHO and UN partners	30,000	0%	100%	-	2022-2024
TA assistance project to design a mechanism to secure funds and guarantee timely disbursement for commodity procurement, and provide support in the implementation phase. Jumpstart the mechanism by committing US\$ 0.64 million from domestic funds (MoH)	MOH, PAHO and UN partners	27,998	90%	10%	-	2022-2024
Establish SOP for forecasting, procurement and Supply Chain management	MOH	4,149	0%	90%	10%	2022-2024
Provide on the job training during a one cycle implementation of recommendations from technical assistance	MOH, PAHO	10,095	0%	100%	-	2022-2024

Table 11: Responsibilities and expected costs (continued)

Strategies and actions	Responsible	total cost US\$	Suggested financing source			Implementation period
			Grant request	MoH	Other partners	
<b>3. Accelerate Roll-out of Social Contracting</b>						
Set new timeline to roll Social Contracting Roadmap and establish Social Contracting Working Group (C-CCM, CSO's)	MOH	242	0%	100%	-	2021 (possible reprogramming of current grant)
Agree on package of services (including Psychosocial Support), finalize costing and approve budget for first pilot	Contracting Working group	10,858	100%		-	2022-2024
Develop new funding options for CSO's and provide training on public contracting, grant finding, and provision and marketing of services for private sector	MOH	18,567	90%	10%	-	2022-2024
Trainings of CSO to engage in strategic discussions and decision making, including hands on training to participate in the regulation of SC	MOH	16,652	90%	10%	-	2022-2024
Develop and approve regulation for SC	MOH and Social Contracting Working group	-	0%	100% HR costs	-	2022-2024
Lunch Social Contracting Pilot	Contracting Working group	98,500	80%	20%	-	2022-2024
<b>4. Find 3,400 PLHIV without diagnosis</b>						
<b>4.1 Address stigma and discrimination</b>						
Establish working group to evaluate and formalize mechanism of redress within the existing justice system, and formally incorporate services provided by CSO's, develop redress flow chart and proposal	MOH, with support of C-CCM and CSO's	2,000	100%	HR administrative costs	-	2022-2024
Technical assistance project to design and implement a strategy for sustained Health literacy and Stigma and Discrimination, using best practices and evidence based strategies		50,000	0%	100%		2022-2024
<b>4.2 Roll-out self testing</b>						
Start feasibility study financed by current grant, which should include the design of distribution, access and provision of self-testing, and pilot on MSM	MOH	4,146	past grant	-		2021
Implement a broadened self test pilot	MOH	16,584	100%	100% HR costs		2022-2024
<b>TOTAL COSTS CURRENT GRANT</b>		<b>9,474</b>	<b>9,474</b>	<b>0</b>		
<b>TOTAL COSTS COMING GRANT *</b>		<b>334,135</b>	<b>208,462</b>	<b>125,673</b>		
<b>TOTAL COSTS</b>		<b>343,609</b>	<b>217,936</b>	<b>125,673</b>		

\* MoH total includes US\$40,000 potentially provided by other development partners through technical assistance or other financing mechanism.

## 5 Conclusions

Suriname has made important progress towards reducing HIV and TB infections and deaths, and reaching the 90-90-90 targets. In particular, important progress has been made in reaching viral suppression among those on ART treatment (90%) and treating those diagnosed (83%). The successful implementation of “test and treat” partially explains these gains. Substantial progress has also been achieved in establishing the HIV information system to track treatment and care, which will undoubtedly be of help to guide the response.

Suriname has also progressed significantly towards Tuberculosis (TB) elimination. TB screening in 2013 was four times the level reached in 2010, 75% of all TB cases were successfully treated in 2015, and as of 2019 98.6% of TB patients know their HIV status.

Amid these important achievements some challenges still remain. There are still 3,400 PLHIV that remain undiagnosed, which means that only 59% of all PLHIV know their status, and people are diagnosed in the later stages of the disease. Undiagnosed persons are an important driver of new infections. Additionally, prevalence among certain groups is high, with 16.6% of men who have sex with men and 10% of male sex workers and Transgender sex workers being HIV positive.

Finding and successfully treating these PLHIV will require stepping-up the response both in terms of resources and programmatic actions. Although the country is well positioned to assume these challenges there are several risks that need to be addressed.

First, Suriname was coming out of a steep economic recession which resulted in increased fiscal deficit and high debt, as well as external imbalances that limited the availability of foreign currency needed to import HIV commodities. The Covid-19 pandemic has halted the nascent economic recovery. Additionally, donor funding is dwindling. PEPFAR is no longer financing activities in Suriname, and the country is transitioning away from Global Fund financing. Transitioning away from donor funding in the midst of a tight fiscal space will require ingenuity and commitment to guarantee continued progress and prevent the gains achieved from being lost.

The largest risk for a sustainable transition is the lack of a continuous and secure flow of funds for HIV. Therefore, it is imperative to **prioritize de development a clear explicit funding strategy**. The funding strategy should identify and quantify the sources of finance to increase annual spending in the amount needed to reach the 90-90-90 targets and advance towards the 95-95-95 targets. Based on the investment case estimations the Sustainability Action Plan recommends **increasing funding by at least US\$1.4 million by 2024**.

Second, an important risk identified during the stakeholder meetings was HIV commodity stock-outs. Stock-outs pose a threat to adequate treatment and discourages the uptake of testing, as people anticipate treatment will not be available. Prevention efforts are also hampered by condom and test stock-outs. Although the stock-outs have been more severe as a result of the current economic and public health crisis, they seem to be more a result of recurring events due to structural factors and inefficiencies in the procurement and supply chain management. Important advances have been made in forecasting commodity needs, but other areas of the supply chain need attention, including securing the funds for purchasing -which play an important role in stock-out events-, advancing pooled

procurement strategies to access better prices, and more efficient distribution of commodities. To address this issue the country would benefit from **technical assistance to identify bottlenecks and inefficiencies in procurement and supply chain management, as well as devising a mechanism to secure the timely disbursement of funds.**

Third, CSOs are heavily funded by donors and provide an important share of services to KP and other PLHIV. Withdrawal of donor funding has already resulted in gains lost. For example, MoH data shows a decrease of 50% in KP outreach outcomes in 2019 compared to 2018, which coincided with the halting of the LINKAGES project financed by PEPFAR. After a steady decrease since 2014 TB also saw an increase in the number of patients in 2017-2018, which coincided with the reduction of funding from GF. **Rolling out social contracting to maintain the gains in reaching KPs is a priority for a sustainable transition.** As mentioned before, Suriname has made important progress towards social contracting, and there is a clear roadmap. However, roll-out of SC has halted. The GF grant for the period ending in 2021 did not include activities to roll-out SC. The next grant should give priority to rolling out SC and implementing the first pilot, with Suriname co-financing the initial stages, through the co-financing requirements and the GF grant financing the first pilot and CSO's trainings.

Fourth, stigma and discrimination are still important drivers of low testing uptake and are a hurdle to reaching the target of having 90% of PLHIV know their status. Stigma and discrimination are not only a result of ingrained, hard to change cultural beliefs, but also of lack of knowledge and information regarding treatment, prevention and modes of transmission. Openly discussing HIV within broader health literacy campaigns, as with any other chronic or infectious disease, may help clear misconceptions, reduce its taboo status and promote testing up-take and healthier behaviors. Suriname has successfully implemented communication campaigns in the past, but these have been sporadic, and gains tend to dilute with time. Making it easier for people to get tested in a confidential way will also promote testing uptake. The action plan suggested the need to **develop a health literacy and communication campaign that can become a routinely part of the HIV response,** rather than a one-time only event. It also recommends **accelerating the roll-out of self-testing.**

In addition to the four strategies recommended in this document, it is important to strengthen the institutional capacity of the HIV program to enable the successful implementation of these strategies and other actions in the HIV response. Ramping up the investments and programmatic response can avert 1,396 death and 1,850 new infections. This will not only result in better health status and quality of life for many but will translate in lower health and health insurance costs for the government, less social assistance requirements, and will prevent loss of productivity due to ill health and death of those affected by HIV.

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## 7 Annex 1

Table 12a: Stakeholders consulted through group interviews

Name	Organization
Mrs. Dr. Monique Holtuin Mr. Dr. Eric Commiesie	MOH-Programmatic
Mr. Georgian Singorawi Mr. Bidjesh Bhoewar	MOH-Finance
Mr. Lucien Govaard Mrs. Dr. Rachel Eersel Mrs. Estrelita Tromp	C-CCM
Mrs. Joy Leter Mrs. Sagita Jaggan	MOF, Staff Members Directorate of Finance
Mrs. Tania Kambel Mr. Kenneth van Emden Mr. Marten Colom Mrs. Denise Blinker Mrs. Denise Carr Mrs. Ethel Pengel	Representatives of NGOs
Mrs. Dr. Sharon van Engelen Mrs. Dr. Chantal Eltenberg	State Health Insurance Foundation (SZF)
Mrs. Dr. Malti Adhin Mrs. Tilotma Ramlal Mr. Merril Wongsokarijo Mrs. Shaline Baldi Mr. Delano Doolkadir Mrs. Phyllis Pinas Mr. dr. John Codrington	Molecular Lab MWI Anton de Kom Universiteit Suriname Central Lab for Serology Laboratory of the Nickerie Regional hospital Academic Hospital Laboratory
Mr. Oscar Mesones Lapouble Mr. Dr. Patrick Matala Mrs. Eng. Judith Brielle Mr. Dr. Michel de Groulard	UN partners and PAHO

Table 13b: Stakeholders consulted through individual interviews

Name	Organization
Ms. Dr Helene Hiwat	MOH-Programmatic, coordinator of Malaria program
Mr. Bijaiprekash Balesar	MOH-Programmatic, Coordinator TB program
Dr. Diana Pinto	IADB Portfolio Manager for Suriname
Mrs. Dr. Deborah Stijnberg	Data system
Mr. Thomas Dowling	IMF Economist for Belize and Suriname



## List of observed NSP consultations

### First round

- KP outreach
- Psycho-social community level
- Multi sectoral
- Acquisition
- Allocation
- e MTCT
- Linkage to care/treatment
- Strategic info
- Co morbidities

### Second round

- Enhance testing services - Scale-up national prevention efforts
- Reach all key and vulnerable populations with customized and targeted interventions
- Scale-up EMTCT for HIV, syphilis and Hepatitis B
- Enhance treatment and care for PLHIV
- Address Co-morbidities and integrate HIV services
- Increase resources for HIV programming (resource acquisition)
- Strengthen human resources for HIV - Strengthen multi-sectoral engagement, roles and relationships to address social and structural drivers of HIV
- Collect strategic information for understanding the epidemic - Enhance data management for ensuring data quality - Strengthen dissemination of information for evidence-based decision making
- Validation workshop/ National consultation meeting

## List of suggested members for the Steering Committee

In representation of the Ministry of Health

Mrs. Monique Holtuin (MoH HIV Focal Point)

Mr. Eric Commiesie (HIV/TB Grant Coordinator PEU-GF)

Mr. Georgian Singorawi (Deputy Director for Finance, MoH)

Mr. Bidjesh Bhoewar (Finance manager GF HIV/TB Grant)

In representation of C-CCM

Chair: Lucien Govaard and

Vice Chair: Rachel Eersel

In representation of PAHO:

Mr. Oscar Mesones Lapouble

In representation of CSOs:

Mrs. Tania Kambel

In representation of the Ministry of Finance:

Mrs. Joy Leter

In representation of UNAIDS:

Mr. Michel De Groulard (Interim Country Director) TBD

## 8 Annex 2: Programmatic Challenges and Achievements

### 8.1 Prevention and Outreach

Although a National Prevention and Communication strategy exists it has not been used to lead and coordinate the prevention activities. The Health in All Policy (HiAP) was adopted in Suriname in 2017 to implement according to WHO Framework for country action<sup>73</sup>, with the purpose to improve population health and health equity. HiAP should facilitate the incorporation of HIV prevention interventions in the national health promotion strategy, but the Ministry failed in the operationalization of the HiAP due to lack of staff.<sup>74</sup>

Prevention activities focusing on the general population and youth were only a few. Among these was a PAHO funded campaign to increase testing by men (“Mijn toffe man”) which combined HIV testing with other health aspects and healthy lifestyle promotion and a behavior change campaign for youth in the interior, which was a Global Fund financed Project. An app was developed containing information in different languages on HIV, Tuberculosis and STI. The Basic Life Skills Program was developed and pilot-tested but as no obligation exists, schools did not implement the package due to time constraints with regard to incorporating the materials into the existing curricula. Taking into consideration the abovementioned, prevention activities focused on key populations and were implemented mainly at the community level.<sup>75</sup>

Civil Society Organizations (CSOs) have enhanced their services to SWs, MSM and Trans populations specifically with support from the Global Fund Project and PEPFAR’s LINKAGES Project. More targeted and structured outreach activities resulted in an increase in key populations being reached with information, education, commodities and testing until 2018. These projects, additional donations from the Brazilian project<sup>76</sup> and private initiatives of the CSOs ensured continued provision of commodities to key population when the Ministry’s stock significantly decreased in 2019 and procurement through the Bedrijf Geneesmiddelen Voorziening Suriname (BGVS) stopped due to financial constraints of the government.

Data from 2019 showed a decrease in outreach that is being linked to the decreased availability of funds when the LINKAGES project was halted. MoH data shows a decrease of 50% in KP outreach outcomes in 2019 compared to 2018. In 2019, 2530 SWs, MSM and Trans persons were reached compared to 5138 reached in 2018. Specifically, SW outreach was 56% in 2016, 78% in 2018, and declined to 46% in 2019.<sup>77</sup>

Condoms are distributed by the National AIDS Program through their distribution center called Libi! which freely gives condoms to individuals but also to different types of organizations e.g. to health institutions, NGO’s working with KP, pharmacies, motels, etc.<sup>78</sup>

### 8.2 Testing and Counseling

HIV testing is accessible through 10 Voluntary-counselling and Testing (VCT) sites in Regional Health Service (RGD) clinics, clinics for SRH (Lobi Foundation) and STI (Dermatological Service), private laboratories and hospital laboratory testing. Since 2016 testing for Key Population is also possible at community level. Provider Initiated Testing and Counseling among specific groups are in place e.g. among pregnant women and TB patients. Physicians also initiate testing when certain symptoms/diseases are diagnosed. During interviews with stakeholders it was mentioned that the

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<sup>73</sup>World Health Organization.(2014). Helsinki Statement Framework for Country Action

<sup>74</sup>Ministry of Health. (2020). Final Draft Evaluation and Situation and Response Analysis of the HIV NSP 2014-2020. Paramaribo: Suriname Government.

<sup>75</sup> Ibid

<sup>76</sup> Agencia Brasileira Coopercao (ABC) project: ‘Strengthening the HIV response in Suriname’, a cooperation between the Brazilian and Surinamese governments

<sup>77</sup>Ministry of Health. (2020). Final Draft Evaluation and Situation and Response Analysis of the HIV NSP 2014-2020. Paramaribo: Suriname Government.

<sup>78</sup>Ministry of Health. (2020). Draft Suriname HIV Epidemiological Profile, 2014 – 2019. Paramaribo: Suriname Government

feasibility of introducing self-testing as a means to increase the number of persons knowing their status will be assessed by the ministry.

Overall the annual number of tests performed in country increased, from 27,300 tests in 2014 to a maximum of 41,182 in 2017. Between 2014 and 2018 a total of 178,705 HIV tests were done of which the vast majority (77%) were among women. It should be noted that women are tested at least twice during pregnancy within the framework of PMTCT. The age group 15-49 years accounted for 88.6% of all 2014-2018 tests and persons 50 years and older contributed for 10.3% of all testes.

The MoH has difficulty reaching and serving key populations due to insufficient coordination of the services and less than optimal/ inadequate communication between the MoH and the CSOs with regard to their interventions. The CSOs are challenged in the implementation of outreach activities including provision of commodities and testing opportunities, as a consequence of reduced funding especially since the ending of the LINKAGES project. During interviews stakeholders repeatedly mention that stigma and discrimination continue to inhibit key populations in accessing (testing) services.

### 8.3 Laboratories

All public and private hospital laboratories perform HIV testing as well as VCT sites of the RGD clinics, the CSOs and the MM posts. HIV test kits and reagents procured by the MoH are distributed to these sites by the Central Laboratory of the Ministry of Health. The testing algorithm for HIV testing in Suriname was updated to serial testing. The laboratory is ISO 15189 certified and conducts quality control for all sites performing HIV tests. Interviewed stakeholders mention that the Central Laboratory and hospital and other laboratories have setup their own quality control mechanisms and refresher trainings being done regularly for staff performing rapid testing. Early Infant Diagnosis (EID), Viral load and CD4 tests are conducted in the Academic Hospital. The MoH procures the reagents for CD4 but the Academic Hospital Paramaribo (AZP) secures the reagents for viral load from its own budget. The Academic Hospital laboratory is the only laboratory that performs viral load and CD4 testing. A representative of this lab noted that decentralized collection of samples is possible, but only if the samples for CD4 reach the hospital within 24 hours. Hence, while CD4 and viral load testing are available for those living in urban and some rural areas, testing is a challenge for PLHIV from remote areas. The laboratory of the Medical Scientific Institute (MWI) also performs the EID and conducts genotyping since 2019.

There is a network of laboratories including private and hospital laboratories and the Central Laboratory. The intention is to strengthen the network and also engage the laboratories from the MM, the RGD and the laboratory of the Medical Scientific Institute (MWI).

A 2017 report regarding a 'Suriname HIV Laboratory Network Plan Review' mentions the existence of a comprehensive "National Strategic Plan for the network of medical laboratories in Suriname 2013-2017" (NLSP) that describes seven themes. It also mentions that a 'National Health Laboratory Policy (NHLP)', which is a critical step to laboratory services improvement and sustainability, was drafted in November of 2017.<sup>79</sup> Whether the policy is finalized and adopted now, is unknown.

### 8.4 Treatment, Care and Support

Treatment became available in Suriname in 2005 with the first Global Fund grant. From the start medication was free for all who receive treatment irrespective of one's nationality or legal status. Treatment continues to be free of charge for every PLHIV and financed by the government of Suriname. As of January 2018, 'Test and Treat' was officially introduced in the country leading to a yearly increase in the number of PLHIV being treated. Data from the Ministry show that though the number of men being treated is increasing the number of women initiating treatment is slightly higher than men. However, the one-year retention on treatment has declined from 81% in 2013 to 63% in 2018. For women the one-year retention decreased even more than in men reaching 58% and 67%

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<sup>79</sup> Van Der Pol, B. (2017). Final Report of the Consultation Visit of 19-20 September 2017.

in 2018 for women and men respectively.<sup>80</sup> Data from 2019 show an increase in ARV- treated persons achieving viral suppression, which might suggest an improvement of retention in the last year.

Ministry staff noted that in 2019 the combination of Tenofovir, Lamuvidine and Dolutogravir (TLD) was introduced in Suriname as the first line drug of choice and as much as possible all newly enrolled patients (500 annually) received TLD. Although an increasing number of PLHIV is treated with this regime, protocols are yet to be updated in 2020, a process impeded by the current COVID-19 epidemic and related problems.

Ministry staff explained that until 2018 stock outs of ARVs, were infrequent as a result of close monitoring and timely forecasting and procurement as well as sufficient domestic funds. It is usual that imminent shortages, due to logistical problem, were supplemented with help from other Caribbean countries until procured drugs arrived.

A challenge for the treatment, that has become more acute with the COVID-19 pandemic and the growing national economic crisis, is the recurring of stock-outs, especially of ARVs and CD4 testing materials due to lack of funds.<sup>81</sup> Moreover as a consequence of lock-downs across the world manufacturers seem to be behind on their delivery schedules, even of drugs that already have been paid for.

### 8.5 Linkage to Care Psycho-social care and support

Of the 500 to 600 newly registered HIV cases annually, approximately 20% of the newly diagnosed are not linked to services and persons from the interior are less likely to be supported than those in urban areas.<sup>82</sup>

PLHIV can access psycho-social support through the CSOs supported by the MoH and the LINKAGES project. The NAP operates the “Peer Counselor” and “Buddy” systems that support CSOs to link PLHIV with peer counselors or buddies in Paramaribo and Moengo. They are assigned to a newly diagnosed person to provide their client with psychosocial support. They help to engage them in care and treatment and to access additional social services as needed. Peer counselors and buddies all receive training on linking clients to services. Physicians and nurses inform the NAP of newly diagnosed HIV positive persons and the NAP refers the persons to the CSOs. The systems have been in existence for years and are considered a national best practice for being successful in supporting clients with ART initiation, adherence and achieving viral suppression.

The LINKAGES project introduced the Health Navigators system, that provides similar services to key populations living with HIV. Health Navigators are employed by the CSOs and conduct outreach, facilitate access to counseling and testing, social services, psychosocial support and linkage to treatment and retention. The CSOs working with key populations in the LINKAGES project also strengthened their support system, because they experienced that urgent material needs of their clients, pushed other issues, including treatment and care to the background. It was necessary to address the material needs, prior to trying to engage clients in medical care. Most pressing needs were food, housing and employment.

Different institutions also developed and implemented their own approach e.g.: The Academic hospital uses a ‘joint medical- social work’-team, Regional Health Service use health workers as buddies. A national system to coordinate the provision of psychosocial care, based on a clear case management system is clearly missing in Suriname.

With support of the LINKAGES project a national ‘Linkage to and retention in HIV care and treatment manual’ was drafted to standardize and document procedures on linking PLHIV at their entry point in the system. This manual could be finalized and complemented with the standardization of psychosocial care guidelines to fill this gap in regulation.

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<sup>80</sup> Ministry of Health. (2020). Draft Suriname HIV Epidemiological Profile, 2014 – 2019. Paramaribo: Suriname Government

<sup>81</sup> Ministry of Health. (2020). Final Draft Evaluation and Situation and Response Analysis of the HIV NSP 2014-2020. Paramaribo: Suriname Government.

<sup>82</sup> Ibid.

## 8.6 Forecasting, Procurement and Supply Chain

The Government of Suriname funds procurement of ARVs. Monthly the Ministry of Health's care and treatment coordinator and the pharmacist from the National AIDS Program (NAP), a staff member in charge of procurement, and another staff member responsible for finance have meetings to forecast the need for drugs and develop cost estimates. The group also meets approximately 6 times per year to do inventory control and forecasting. The procurement process is initiated when nine months of stock remain in the Drug Supply Company Suriname ( Bedrijf Geneesmiddelen Voorziening Suriname (BGVS)<sup>83</sup> <sup>84</sup>. This company is participating in the monitoring and forecasting meetings of the Ministry of Health. At the start of the procurement process the BGVS submits a purchase order with which the NAP (through structures of the MoH) requests funding for drugs. The ministry requests the funds from the Ministry of Finance. A special policy measure in the government budget exists for HIV from which the MoF can draw funds for the MoH. Upon approval of the MoF and receipt of funds by the NAP, the NAP forwards the funds to the BVGS which then procures the ARV at Indian manufacturers. The BGVS procures based on open market principles. Due to lack of familiarity with the procedures and processes of the PAHO Strategic Fund in program staff and (assumed) lengthy procedures in BGVS staff, the PAHO Strategic Fund –mechanism was not used. With increased understanding of the Funds mechanism the ministry has recently initiated procurement of 2 ARVs through the Strategic Fund.

According to MoH-HIV focal point occasional stock-outs of ARVs were due to delays in accessing funding as a consequence of complex processes for accessing Government funding. Until 2019 the BVGS and the NAP have been able to minimize interruptions in providing ARVs to PLHIV during the past years. Since the economic downturn though imminent shortages are more frequent and Suriname needs to turn to neighboring countries for support in supplementation. The TB program orders according to the same process through the BGVS. Due to the fact that the amount of medicines needed for TB is far less than the ARV, the funds do not seem to be an issue. In the past 5 years there have been no stock outs for TB medication as the BGVS stores stock for more than 1 year.

According to program staff forecasting, inventory control and procurement processes have been developed and need to be documented and formalized.

Antiretroviral therapy is available and distributed through five ARV dispensing pharmacies, four within Paramaribo and one in Nickerie district in the north-west of the country. Due to the COVID-19 pandemic and the country's inability to keep sufficient stock, these pharmacies are currently allowed to keep only 1-2 months of stock of ARV. This complicates the implementation of multi-month prescription strategies that are proven to have a positive impact on treatment adherence.

With regard to condoms the Ministry of Health procures condoms and lubricants and distributes them free of charge. Condom distribution has dropped over the past few years. The MoH does not have a separate policy regarding condoms however it did prepare an HIV prevention and communication strategy in 2018. This draft strategy has minimal focus on condom procurement and distribution policies, despite the Investment Case exercise identified condom promotion as the most cost-effective intervention to prevent new HIV infections.

## 8.7 Human Resources

Several positions in the ministry related to the HIV and TB response were and a few still are financed by development partners. The MoH is challenged by a high rate of attrition of staff.

According to the HIV focal point, all NAP staff and support staff (HIV focal point, 2 administrative employees, 1 employee for condom distribution, 1 M&E employee, the PMTCT focal person, buddies and peer counselors, 1 pharmacist) is paid from government budget.

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<sup>83</sup> The BGVS is the company that procures all drugs, reagents and commodities ordered and/or approved by the Government, according to a selection of "essential medicines" for the country. The company also imports pharmaceutical raw materials and medical consumables.

<sup>84</sup> Each ARV seems to have its own procurement cycle and thus procurement of ARV happens several times a year.

## 8.8 NSP Process

A review of key programmatic documents, available data on NSP performance indicators and consultations with stakeholder groups based on thematic areas was the first step in the development of the 2021 NSP. The consultations with each stakeholder group were structured in order to collect information on:

- Progress of interventions mentioned in the NSP 2014-2020
- Implementation challenges
- Program priorities for the next NSP.

The stakeholders to be consulted were selected in collaboration with staff from the Ministry of Health (MoH) and the Core Group. The evaluation team provided periodic updates to the Core Group of stakeholders via conference calls every two weeks as well as through periodic e-mail communications. Information sharing across the two consultancy groups took place because of the complementary nature of the NSP consulting teams' assignments and that of a consulting team charged with developing the sustainability plan. Coordination and collaboration took the form of a representative from the Pharos team participating on the evaluation team's consultation and a representative from the evaluation team joining on Pharos's consultations.

In a second round of stakeholder consultations the identified program priorities for the next strategic planning period were discussed by goal, strategic objective, priority area, related Intervention and key activity. A national consultation concluded the consultation activities and initiated the NSP formulation/development period.

## 9 Annex 3: Progress on implementation of TWP.

(See accompanying excel workbook)

## 10 Annex 4: Initial priority goals and actions identified through stakeholder consultations

Key strategic goals identified by stakeholders	Actions/strategies identified in the TWP	Additional actions (Preliminary)
<p>1. Increase domestic financing sources, identify sources of savings and improve efficiency in the current use of resources</p>	<ul style="list-style-type: none"> <li>Investment case and some effectiveness studies have been finalized.</li> <li>Develop an advocacy strategy with the results from the investment case</li> <li>Develop strategies for optimizing use of available resources, including Collaboration/coordination b/w MoF and MoH</li> <li>Explore if there are ways and it is relevant to implement cost recovery mechanisms for patients covered by private and public health insurance. Should certain services be included as part of health package? Including evaluating risks to access for uninsured persons</li> </ul>	<ul style="list-style-type: none"> <li>Explore innovative funding approaches through private sector engagement</li> <li>Incorporate HIV in other strategic actions such as emergency preparedness, chronic conditions, etc. to access other external/domestic funding</li> <li>Explore debt forgiveness programs in exchange for investments in health</li> </ul>
<p>2. Stock-outs in CD4 tests and reagents, condoms and lubs, and ARV's procured by MoH</p>	<ul style="list-style-type: none"> <li>Institutionalize use of forecasting based on programmatic and consumption data for procurement of quality health products (medicines)</li> <li>Address other aspects of supply chain management have not been addressed</li> </ul>	<ul style="list-style-type: none"> <li>TA or South-South exchanges to identify bottle-necks in procurement and supply chain management of ARV's tests and reagents, and recommend actions for improvement. This includes revising alternative procurement arrangements and finance mechanisms and/or consolidating all procurement in BVGS. <u>A mechanism to guarantee stability of funding.</u></li> <li>Continue to advance procurement through PAHO Strategic Funds to guarantee lower prices and explore emergency alternatives to pre-payment arrangements</li> </ul>
<p>3. Strengthen coordination, communication, and organizational capacity within MoH HIV program</p>	<ul style="list-style-type: none"> <li>Addressed indirectly in TWP</li> </ul>	<ul style="list-style-type: none"> <li>Short term organizational and strengthening needs.</li> <li>Define organizational structure of the HIV program within the MoH or Bureau of Public Health.</li> <li>Define roles and responsibilities and</li> </ul>

		<p>linkages to other units within MoH/Bureau</p> <ul style="list-style-type: none"> <li>• Also going to be addressed in the NSP.</li> <li>• Define role and ways to institutionalize the roles C-CCM (there is the evolution policy of C-CCM). Coordinating mechanism to involve stakeholders*.</li> </ul>
4. CSO's sustainability	<ul style="list-style-type: none"> <li>• Analysis of cost-effectiveness of health interventions by CSO's and derive lessons and identify if there is scope for increased efficiency.</li> <li>• Strengthen the capacity of CSOs to engage in strategic discussions and decision making</li> </ul>	<ul style="list-style-type: none"> <li>• Update timeline for implementation of SC plan</li> <li>• Initiate discussions with MoH and MoF on SC plan, and identify and implement 2-3 activities to roll-out SC</li> <li>• Define and cost psychosocial services that might be part of SC package</li> <li>• Identify alternative sources of funding, including funding of psychosocial services</li> </ul>
5. Information system	<ul style="list-style-type: none"> <li>• Include financial information</li> <li>• Improve on unique person identifier across services and sectors</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a strategy to institutionalize and disseminate information</li> <li>• Find ways to integrate information system for HIV within MoH, and guarantee finance.</li> <li>• Identify synergies with IADB projects (Possible TA)</li> </ul>
6. Improve access to testing and care	<ul style="list-style-type: none"> <li>• Development a roadmap of HR desk – agree where it should be placed and how to finance, how will it operate (who is responsible, etc.).</li> <li>• Activities to reduce of stigma and discrimination.</li> <li>• Develop migrant strategy</li> </ul>	<ul style="list-style-type: none"> <li>• TA to address segmentation and barriers to health insurance (Possible TA)</li> <li>• Eliminate sensitive questions from request for subsidized health insurance (Job for SW and medical information for all)</li> <li>• Include health literacy in Communication campaign</li> <li>• Roll-out self-test: feasibility study, who will finance and linkage to care</li> <li>• continue roll-out of PREP/PEP</li> <li>• Continue advancing TLD treatment, according to WHO guidelines – updating guidelines</li> </ul>